

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02300

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ~~10 DAYS~~Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL

How long in hospital or institution? 9 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ALLEGANY

City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 180 WINEOW ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ELECT ALLEN

4. Sex MALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife TREMBLES ANNIE

7. Birth date of deceased (mo., day, yr.) June 16 1875

8. AGE: Years 72 Months 9 Days 2 If less than one day hrs. min.

9. Birthplace Faber VA  
(Town, county, and state)

10. Usual occupation WPA

11. Industry or business Labor

12. Name ALLEN WILLIAM

13. Birthplace Faber Va

14. Maiden name MOORE ANNIE

15. Birthplace Faber Va

16. Informant John Allen

Address 512 Hill St, Cumberland, Md.

17. Burial Date thereof 3/21/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sumner Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. March 20, 1948 W. H. Treutz, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

214-05-7574A

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 18 1948 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1948 to March 18 1948 and that I last saw him alive on March 18 1948

Immediate cause of death Respiratory failure  
Due to Pulmonary Tuberculosis  
Due to Tubercula pneumonia  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Simon

M. D. or other

Address Memorial Hospital Date signed 3/18/48

RECEIVED

MAR 23 1948

BUREAU V. S.

*Encl. 10*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02381

4

## 1. PLACE OF DEATH:

County AlleganyCity or town 109 Arch St. Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 Years

Hospital, institution, or street address where death occurred:

109 Arch St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 789 Fayette St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Mary Louise Andrews

## 3. (b) Social Security Number

None

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white married6.(b) Name of husband or wife James E. Andrews7. Birth date of deceased (mo., day, yr.) Feb. 10-1902

8. AGE: Years Months Days If less than one day

46 1 8 hrs. min.9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name William M. Birchard13. Birthplace Warren Ohio14. Maiden name Carrie A. Birchard15. Birthplace Cumberland Md.16. Informant James E. AndrewsAddress 789 Fayette St, Cumberland, Md.17. Burial Date thereof 3/21/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. March 20 19 48 W. K. Tautz M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 48 at 9.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. er Dead March 18 19 48

Immediate cause of death

Cardio-pulmonary hemorrhage at onceDue to Accidentally discharged  
38 caliber automatic revolver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-18-48Where did injury occur? Cumberland Allegany Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) 109 Arch St.Means of injury as aboveInjured at work? noDeputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or otherAddress Cumberland Md. Date signed 3-19-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 23 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr J N Reeves  
2411 N. Charles St., Baltimore 94a  
CERTIFICATE OF DEATH

Reg. Dist. No. 02302  
6

1. PLACE OF DEATH: Allegany  
County.....  
City or town..... Barton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 43 years  
Hospital, institution, or street address where death occurred:  
Eutaw  
How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Barton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Latrobe St  
(If rural, give LOCATION)  
2.(a) If veteran, name war - - - - -

3. (a) FULL NAME WILLIAM COURTNEY ANDREWS

3. (b) Social Security Number  
- - - - -

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife - - - - -  
6. (c) If alive, give age - - - - - years  
7. Birth date of deceased (mo., day, yr.) October 27, 1904  
8. AGE: Years Months Days If less than one day  
43 4 14 hrs. min.

9. Birthplace Barton, Allegany, Maryland  
(Town, county, and state)  
Merchant  
10. Usual occupation  
11. Industry or business Grocery and Meat Business

12. Name William H. Andrews  
13. Birthplace Barton, Maryland  
14. Maiden name Carrie Michaels  
15. Birthplace Firm Rock, Maryland  
16. Informant Graydon C. Andrews  
Address Barton, Maryland

17. Burial Date thereof March 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Laurel Hill Cemetery  
Location Moscow, Maryland  
18. Funeral director Ellsworth S. Boal  
Address Westernport, Maryland

19. Mar. 15 1948 Registrar  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 10:15a M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1948 to March 11 1948  
and that I last saw him alive on March 11 1948

Immediate cause of death  
Coronary Occlusion  
Due to Coronary Sclerosis  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Norman Reeves, M.D.  
M. D. or other  
Address Westernport Md Date signed 3-13-48

RECEIVED

MAR 18 1948.

BUREAU V. S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02303

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 45 Years  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1014 Virginia Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Barrett

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife John H. Barrett  
 6.(c) If alive, give age 61 years  
 7. Birth date of deceased (mo., day, yr.) October 27 1888  
 8. AGE: Years 59 Months 4 Days 5 If less than one day  
 hrs. min.

9. Birthplace Martinsburg, Morgan Co W. Va.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

MOTHER FATHER  
 12. Name Henry Schad  
 13. Birthplace Martinsburg, W. Va.  
 14. Maiden name Lydia Miller  
 15. Birthplace Martinsburg, W. Va.

16. Informant John H. Barrett  
 Address 1014 Virginia Ave. Cumberland, Md.  
 17. Burial Date thereof 3/5/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Hill Crest Burial Park  
 Location Cumberland, Md.

18. Funeral director William H. Kight  
 Address Cumberland, Md.

19. March 5, 1948 W. R. Lantz, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 48 at 9-45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 19 48 to March 2 19 48  
 and that I last saw him alive on March 2 19 48

Immediate cause of death coronary heart failure DURATION 4 weeks

Due to chronic myocarditis 2 years

Due to acute coronary infarct 1/2 year  
infarct

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE W. R. Lantz, M.D. M. D. or otherAddress 54 Green St. Date signed 3-2-48

RECEIVED

MAR 9 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02304

Reg. Dist. No. 8

## 1. PLACE OF DEATH:

County AlleganyCity or town Moscow  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrsHospital, institution, or street address where death occurred:  
LHow long in hospital or institution? L

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Moscow  
(If outside city or town limits, write RURAL and give nearest town)Street No. L  
(If rural, give LOCATION)2.(a) If veteran, name war L

## 3. (a) FULL NAME

Isaac Peter Bowman

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Matilda Doman Bowman7. Birth date of deceased (mo., day, yr.) Sept 19, 1859 6. (c) If alive, give age L years8. AGE: Years 88 Months 5 Days 17 If less than one day  
hrs. min.9. Birthplace Mar Romney, N. Va.  
(Town, county, and state)10. Usual occupation Farming11. Industry or business Own Farm12. Name Henry Bowman13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Noah BeamanAddress Moscow, Ind.17. Burial Date thereof Mar 8, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill CemeteryLocation Moscow, Ind.18. Funeral director M. EichhornAddress Laconing, Ind.19. 3-8 19 48 Janette M Boal

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 48 at 4 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 48 to March 6 19 48 and that I last saw him alive on March 6 19 48Immediate cause of death Cardiovascular Renal DiseaseDue to arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. E. Berry M. D.Address Piedmont W. Va. M. D. or otherDate signed 3/7/48

RECEIVED

MAR 19 1948

BUREAU V. S.

2

## EVIDENCE FOR CHANGE OF AGE

and birth date shown on:

FILM No. G 115 APR 26 1948 CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore

1246  
02305

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... ALLEGANY  
 City or town... CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? 3 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... GARRETT  
 City or town... GRANTSVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

DR. THOMAS O BROADWATER

## 3. (b) Social Security Number

None

4. Sex... MALE 5. Color or race... WHITE 6.(a) Single, married, widowed, or divorced... MARRIED  
 6.(b) Name of husband or wife... Ethel EBER BENDER  
 7. Birth date of deceased (mo., day, yr.)... APRIL 3, 1892 1891  
 8. AGE: Years... 56 Months... 11 Days... 23 If less than one day... hrs. .... min. ....

9. Birthplace... MARYLAND  
 (Town, county, and state)  
 10. Usual occupation... DENTIST  
 11. Industry or business

12. Name... JAMES BROADWATER  
 13. Birthplace... MARYLAND  
 14. Maiden name... MARION FROST  
 15. Birthplace... MARYLAND

16. Informant... Ethel Broadwater (wife)  
 Address... Grantsville, Md.

17. Burial Date thereof... March 28, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Salisbury, Md.  
 Location... Salisbury, Md.

18. Funeral director... William Winterberg  
 Address... Grantsville, Md.

19. March 27, 1948 W. F. Williams, M.D.  
 (Date rec'd by registry) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... MARCH 26 19... 48 at... 7:05 A

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from  
Jan 21 19... 48 to... 3-26 19... 48  
 and that I last saw him alive on... 2-26 19... 48

Immediate cause of death... Lymphosarcoma  
 (City or town) (County) (State)  
 Due to... Biliary  
 Due to...  
 Other conditions...

(Include pregnancy within 3 months of death)  
 Major findings of operations... None  
 Date of op... None  
 Autopsy results... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury... Injured at work?  
 23. SIGNATURE... W. F. Williams  
 Address... Cumberland Date signed... 3/26/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

02306

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County Allegany  
City or town Cresaptown (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Tripple Lakes  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State W. Va. County Mineral  
City or town Fort Ashby  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Main St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Nannie B. Broom

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Lewis J. Broom  
7. Birth date of deceased (mo., day, yr.) — 1868  
8. AGE: Years 80 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Fort Ashby, W. Va.  
(Town, county, and state)  
10. Usual occupation Housewife

11. Industry or business  
12. Name James Dowden  
13. Birthplace W. Va.  
14. Maiden name Nancy Long  
15. Birthplace W. Va.

16. Informant Mr. Lewis J. Broom  
Address Fort Ashby, W. Va.

17. Burial  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or crematory Fort Ashby, Cem.  
Location Fort Ashby, W. Va.

18. Funeral director Charles L. George  
Address Cumberland Md.

19. March 9, 1948  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5, 1948, 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1948 to March 5, 1948  
and that I last saw him live on March 4, 1948

Immediate cause of death Cerebral Hemorrhage DURATION 13 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE J. E. Johnson, M.D. M. D. or other  
Address Cumberland Md. Date signed 3-8-48

RECEIVED

MAR 11 1948

BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

02307

FILM No. G 114 MAR 29 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred: Memorial Hospital  
How long in hospital or institution? 30 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MARYLAND County GARRETT  
City or town DEER PARK, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

LINDA LEE BRYANT  
4. Sex FEMALE 5. Color of race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JULY 14, 1934  
8. AGE: Years 38 Months 8 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace WV GRAFTON, W. VA.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name HARLACE A. BRYANT  
13. Birthplace LITTLE ROCK, ARKANSAS  
14. Maiden name THELMA JANICE MELTON  
15. Birthplace BENTON, ARKANSAS

16. Informant Memorial Hospital  
Address Cumberland, Md  
17. Burial Date thereof March 18, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory FAIRPLAY  
Location FAIRPLAY, ARKANSAS

18. Funeral home BOLDEN FUNERAL HOME  
Address OAKLAND, MD.

19. March 15 1948 Registrar  
(Date rec'd by registrar)

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1948 at 1245 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 - 1948 to March 15 1948  
and that I last saw her alive on March 14 - 1948

Immediate cause of death

Tubercular meningitis  
Due to \_\_\_\_\_  
Due to Generalized tubercular meningitis  
Other conditions \_\_\_\_\_

DURATION  
2 1/2  
new  
2 new

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

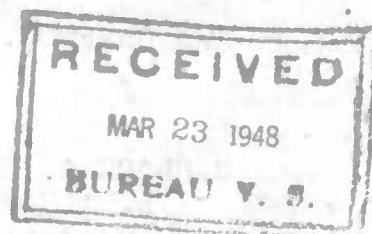
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work?

23. SIGNATURE E. L. Owens M.D.  
Address Cumberland Md Date signed 3-15-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02308

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 yrs.  
Hospital, institution, or street address where death occurred:  
Allegheny Hospital  
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 877 Maryland Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Annie Jane Carroll

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife John N. Carroll  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) May 19 1871  
8. AGE: Years 76 Months 10 Days 12 If less than one day hrs. min.

9. Birthplace Cumtelsville Penna  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Henry A. Walker

13. Birthplace Pa

14. Maiden name Julia Fetterman

15. Birthplace Pa

16. Informant Mrs Cecil Colbert

Address Cumberland

17. Burial Date thereof Apr 3 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumtelsville

18. Funeral director Louis Stein

Address Cumtelsville

19. April 2 19 48 W. J. Sautz, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 48 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 19 48 to March 31 19 48

and that I last saw him alive on March 30 19 48

Immediate cause of death intestinal obstruction

Due to carcinoma of the sigmoid

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County Allegany  
 City or town Mc Coole, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 52 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany  
 City or town Mc Coole  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 57 Howard  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

Clarence Miller Clark

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower  
 6. (b) Name of husband or wife Mary Ellen Stagg Clark  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 20-1875  
 8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westernport Md.  
 (Town, county, and state)  
 10. Usual occupation retired B&O.R.Ry carman  
 11. Industry or business

12. Name Simon Clark  
 13. Birthplace Allegany Co., Md.  
 14. Maiden name Eliza Dayton  
 15. Birthplace Allegany Co., Md.

16. Informant Wallace C. Clark  
 Address McCoole, Md.

17. Burial Date thereof 3/18/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Dawson Cemetery  
 Location Dawson Md.

18. Funeral director B.W. Markwood  
 Address Keyser, W. Va.

19. Mar 18 19 48 W. H. Deming  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

about

20. DATE OF DEATH March 15 19 48 at 6.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead March 15 19 48

Immediate cause of death Coronary occlusion DURATION at once

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

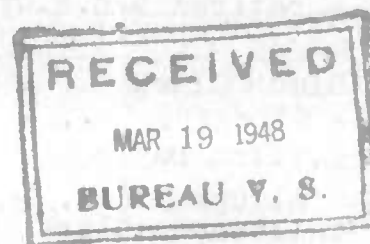
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.Address Cumberland Md. Date signed 3-15-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02310

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs  
 Hospital, institution, or street address where death occurred:  
104 N. Mechanic St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 104 N. Mechanic St.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war 2

## 3. (a) FULL NAME

Harry Cole (Cole)

## 3. (b) Social Security Number

233-09-1759

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Dec. 24-1884  
 8. AGE: Years 63 Months 2 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Oakland Md.  
(Town, county, and state)10. Usual occupation writer11. Industry or business Shrine Good Country Club12. Name Richard Gmt (Step-Father)13. Birthplace Cumberland Md.14. Maiden name Carlina-Cole15. Birthplace Maryland16. Informant Daniel BanksAddress 418 Pine Ave. Cumberland, Md17. burial Date thereof March 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Summer CemeteryLocation Cumberland Md18. Funeral director Louis Stair, Inc.Address Cumberland Maryland19. 3/12 19 48 W. F. Fautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

about

20. DATE OF DEATH March 10 19 48 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him in bed March 10 19 48

Immediate cause of death \_\_\_\_\_

Coronary occlusion

## DURATION

at  
once

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

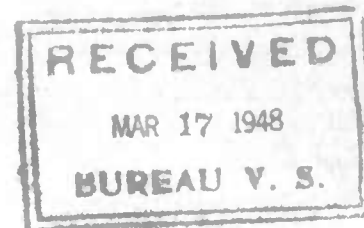
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or \_\_\_\_\_Address Cumberland Md. Date signed 3-10-48



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

02311

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Allegheny County Infirmary  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Fort Cumberland Hotel  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME Nathan Cowen

3. (b) Social Security Number  
?

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Unknown

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Unknown 1892 6.(c) If alive, give age ? years

8. AGE: Years 76 Months ? Days ? If less than one day ? hrs. ? min.

9. Birthplace Lithuania  
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant George Kline

Address 405 Virginia Ave. Cumberland

17. Burial Date thereof Mar 25, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory East View Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer  
Address Cumberland Md

March 25 19 48 W.R. Tautz, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 19 48 at 1:00 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 19 45 to Mar 23 19 48  
and that I last saw him alive on Mar 17 19 48

Immediate cause of death Acute myocardial failure DURATION 3 min

Due to due to senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other  
Address 1105 Centre St Date signed 3-24-48

RECEIVED

MAR 30 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83c

02312

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 yrs

Hospital, institution, or street address where death occurred:

26 Marion St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 26 Marion St  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Mrs Josephine May Davis

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, or divorced

married

## 6. (b) Name of husband or wife

Harry E. Davis

## 7. Birth date of deceased (mo., day, yr.)

July 17 1891

## 6. (c) If alive, give age... years

## 8. AGE:

Years

Months

Days

If less than one day

56725

hrs.

min.

## 9. Birthplace

Westernport, Allegheny Co., Md.

Town, county, and state

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Mar 16 1948

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

March 13 1948

(Date rec'd by registrar)

W.H. Funk, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948 at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1948 to March 1948and that I last saw h. alive on March 10 1948Immediate cause of death Pneumonia

## DURATION

5 daysDue to Debility from chronic arteriosclerosis, 2 1/2 yrsHypertension & encephalomalacia.

Due to

Other conditions Psychosis secondary toCerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R.W. Heston, Jr. M.D.

M. D. or other

Address Cumberland MdDate signed Mar 13/48



RECEIVED

MAR 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02313

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Near Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 Yrs  
Hospital, institution, or street address where death occurred:  
Valley Road, Bowmans Addition, Rt. #3  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Near Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 3 Valley Road, Bowmans Addition  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Jesse Reed Dicken

3. (b) Social Security Number  
220-10-2468

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Mrs Edith (Winter) Dicken 6.(c) If alive, give age 58 years  
7. Birth date of deceased (mo., day, yr.) Feb 1, 1888  
8. AGE: Years 60 Months I Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bedford Valley, Penn.  
(Town, county, and state)

10. Usual occupation Laborer B&O Railroad

11. Industry or business

MOTHER FATHER 12. Name Meri Dicken  
13. Birthplace Cumberland, Md.

14. Maiden name Alice Brent 15. Birthplace Pennsylvania

16. Informant Mary E. Dicken  
Address Rt. #3 Bowman's Addn, City

17. Burial Date thereof April 1, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Zion Memorial Park

Location Bedford Road, Cumberland, Md.

18. Funeral director John E. Yorkford  
Address Cumberland, Md.

19. Date rec'd by registrar April 1, 1948 Registrar W. H. Mertz, M.D.

MEDICAL CERTIFICATION

2D. DATE OF DEATH 3/30/48 19\_\_\_\_ at 11 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/19/46 19\_\_\_\_ to 3/30/48 19\_\_\_\_  
and that I last saw him alive on 3/30/48 19\_\_\_\_

Immediate cause of death Cerebral Thrombosis DURATION 24 hrs

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Richard J. Williams, M.D. M. D. or other  
Address Cumberland, Md. Date signed 3/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1943

BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

02314

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? about 3.1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 470 Goethe St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Miss Semilda Durst

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 15-18738. AGE: Years Months Days If less than one day  
74 11 28 hrs. min.9. Birthplace Barton Md. Allegany County  
(Town, county and state)10. Usual occupation retired housewife

11. Industry or business

12. Name Alphus Henry Durst13. Birthplace Grantsville Md.14. Maiden name Philadelphia15. Birthplace Barton Md.16. Informant Miss Etha M. DurstAddress 470 Goethe St.17. Burial Date thereon March 16 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Laurel Hill CemLocation Moscow Md.18. Funeral director E. S. BoalAddress Westport Md.19. March 14 19 48 W. H. Fantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 48 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
..... 19..... 19.....  
and that I last saw him/her alive on March 13 19 48Immediate cause of death Multiple 3rd. degree burns all over body and shock  
DURATION about 4 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-13-48Where did injury occur? Cumberland Allegany Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury Cloths caught fire from a coal stove.Deputy Medical Examiner = Allegany23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or otherAddress Cumberland Md. Date signed 3-13-48

RECEIVED

MAR 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02315

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 13 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town ACCIDENT  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

FIKE, LAVONNE

## 3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) JAN 16, 1948 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day

FEBRUARY 1 22 hrs. min.

9. Birthplace MARYLAND ALLEG. Co.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name FIKI, DARUIS

13. Birthplace MARYLAND

14. Maiden name DEAL, RUTH

15. Birthplace MARYLAND

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof 2-10-1948  
(month) (day) (year)

Cemetery or crematory accident

Location accident Md

18. Funeral director Mrs. Winterberg

Address Grantsville

19. March 10 1948 Date rec'd by registrar Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 8 1948 at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1948 to March 8 1948

and that I last saw him alive on March 8 1948

Immediate cause of death High labor pneumonia - upper &amp; former lobes.

DURATION

18 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

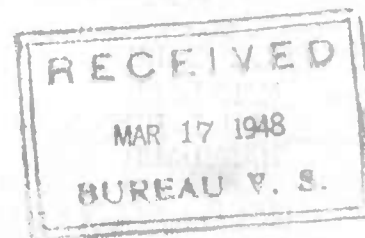
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address 126 Turner St. Cumberland Md Date signed 3/9/48



*Mr. J. Edgar Hoover*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02316

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? about 2 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Rawlings  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harry Lee Flanagan

## 3. (b) Social Security Number

720-10-2473

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Evelyn Grogg Flanagan

## 7. Birth date of

deceased (mo., day, yr.) Aug. 12-19136. (c) If alive, give age 35 years

## 8. AGE:

Years

Months

Days

If less than one day

3471

hrs.

min.

9. Birthplace Red Bank, N. Va.  
(Town, county, and state)10. Usual occupation Track worker for B&O.R.Ry

## 11. Industry or business

12. Name William Hess Flanagan13. Birthplace W.Va.14. Maiden name Rebecca Simons15. Birthplace W.Va.16. Informant Mrs. Harry L. Flanagan

Address

17. Burial Date thereof Mar 15 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Louis Stein Inc

Address

19. March 15, 1948 W.R. Rautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1948 at 7:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,

and that I last saw him Dead March 13, 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

about 1 hourDue to Rupture of a congenital aneurysm of the brain.

\* \* \* (Circle of Willis)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or O.Address Cumberland Md. Date signed 3-13-48

RECEIVED

MAR 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02317

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 monthsHospital, institution, or street address where death occurred:  
Allegany HospitalHow long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County AlleganyCity or town Six Mile House near Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Dale Genevie

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept 20, 1947

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

060

hrs.

min.

9. Birthplace Cumberland, Allegany Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Child

## 11. Industry or business

12. Name Charles A. Genevie13. Birthplace Cumberland Md14. Maiden name Erma Shelly15. Birthplace Cresaptown Md.16. Informant Charles GenevieAddress R.F.D. 1 Cumberland Md.17. Burial Date thereof Mar 23, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Ambrose Catholic CemeteryLocation Cresaptown, Md.18. Funeral director John J. HaferAddress Cumberland, Md.19. March 22, 48 W.H. Frantz, M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 48 at 10:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18 19 48 to March 20 19 48and that I last saw him alive on March 20 19 48

## Immediate cause of death

central pneumonia  
(pneumonia)

## DURATION

Due to infectious

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results central pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. M. M. M.D.

M. D. or other

Address 59 Greene St. Date signed 3-22-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 30 1948

BUREAU Y. S.

DR. COOPER

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02318

107

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? 6 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 475 Willowbrook Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

ARDEN FRANKLIN GILLASPIE

## 3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1948  
 8. AGE: Years Months Days It less than one day  
2 1 hrs. min.

9. Birthplace Maryland, Cumberland, Alleg Co  
 (Town, county, and state)  
 10. Usual occupation Infant

11. Industry or business

12. Name FRANK A. GILLASPIE  
 13. Birthplace West Virginia

14. Maiden name BESSIE DAVIS  
 15. Birthplace West Virginia

16. Informant Frank A. GillaspieAddress 475 Willowbrook Rd. Cumberland, Md

17. Burial Date thereof Mar. 23, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Augusta Cem.Location Augusta, W. Va.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19. March 22, 1948 W.L. Fantz, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 21 19 48 at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 hours 19 48 to 21 hours 19 48  
 and that I last saw him alive on 21 hours 19 48

Immediate cause of death Broncho - Pneumonia DURATION approx 10 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Broncho - Pneumonia Date of op.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. S. Cooper M.D. M. D. or otherAddress 101 S. Centre St. Date signed 21 hours 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 30 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02319

Dr. W. F. Williams

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarrettCity or town Accident

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

B.

Mr. Judson Glotfelty

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Cora Morris7. Birth date of deceased (mo., day, yr.) Nov. 28, 1878 If alive, give age 47 years8. AGE: Years 69 Months 3 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Accident, Md. (Town, county, and state)10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

12. Name Mahlon Glotfelty13. Birthplace Maryland, McHenry14. Maiden name Jane Boyer15. Birthplace Maryland, Garrett County16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial Date thereof Mar 24, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mr. Glotfelty Family Cem.Location Accident, Md.18. Funeral director Emory BoldenAddress Oakland, Md.19. March 24, 1948 W. H. Frantz, M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 19 48 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/15 19 48 to March 21 19 48and that I last saw him alive on 3/21/48 19 48Immediate cause of death Coronary failureDue to Chronic myocardidegeneration -

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

\_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George M. Brown M. D.Address Memorial Hosp Date signed 3/21/48

RECEIVED

MAR 30 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02320

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Miners Hospital  
 How long in hospital or institution? 18 hours and 43 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route #5 Box 294  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Baby Boy Glover

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

March 4, 1948

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

It less than one day

18 hrs.

43 min.

## 9. Birthplace

Frostburg, Allegany, Md.

(Town, county, and state)

## 10. Usual occupation

Laborer None

## 11. Industry or business

FATHER

## 12. Name

Charles Maurice Glover Jr.

## 13. Birthplace

Fairbanks, Pennsylvania

MOTHER

## 14. Maiden name

Beulah Anita Lewis

## 15. Birthplace

Frostburg, Md.

## 16. Informant

Address

Mr. Glover, Rt #5 Box 294 Cumberland Md

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

March 5<sup>th</sup>, 1948

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Maryland

## 18. Funeral director

Jacob J. Zeller

Address

23 E. Main St Frostburg, Md

## 19.

(Date rec'd by registrar)

19

48 Mrs. Nancy K. Roe

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 48 at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 19 48 to March 5 19 48 and that I last saw him alive on March 5 19 48.

## Immediate cause of death

Prematurity (6-6 1/2 mo) (wt 2 lbs 8 oz)

## DURATION

18 hrs

## Due to

Placenta previa of mother

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Hilda Jauris Walters, M.D.

M. D. or other

Address Frostburg Md Date signed 3/5/48

RECEIVED

MAR 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02321

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MineralCity or town Ridgely  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 Ridgely St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Raymond Gray

7. Birth date of

deceased (mo., day, yr.)

Sept 3 1918

8. AGE:

Years

Months

Days

If less than one day

2969

hrs.

min.

8. Birthplace

Keyser W. Va.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at Home

MOTHER

FATHER

12. Name

Joseph Whitt

13. Birthplace

W. Va.

14. Maiden name

Sylvia York

15. Birthplace

W. Va.

16. Informant

Raymond Gray

Address

Ridgely W. Va.

17. Burial

(Burial, cremation, or removal. Which?)

Shelburne Cem.

Date thereof

Mar 15 48  
(month) (day) (year)

Cemetery or crematory

near Cumberland Rd

Location

Thomas Stein Inc

18. Funeral director

Cumberland

Address

March 13 19 48

(Date rec'd by registrar)

W. B. Brantz, M.D.

Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 48 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 48 to March 12 19 48and that I last saw him alive on March 12 19 48

Immediate cause of death

Lobar Pneumonia

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operation

Operation + 2 Cholecystitis  
and appendicitis Date of op. 3-15-48

Autopsy results

Lobar Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. E. Johnson, M.D.Address Cumberland W. Va. Date signed 3-12-48

RECEIVED

MAR 17 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02322

Reg. Dist. No. 10

## 1. PLACE OF DEATH:

County Allegany  
 City or town Mt Savage  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Mt Savage  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Wm. Franklin Griffith

## 3. (b) Social Security Number

214-07-1017

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 16<sup>th</sup> 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 15 1947 to March 16 1948and that I last saw him alive on March 16 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 months

Due to

Vascular Hypertension

Due to

Other conditions

Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

William E. Mosley M.D.

M. D. or other

Address

Mt Savage Md.Date signed 3/16-1948

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Agnes Griffith

7. Birth date of deceased (mo., day, yr.)

Oct 15 - 1882

6. (c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

6551

hrs.

min.

9. Birthplace

Marysville Pa.  
(Town, county, and state)

10. Usual occupation

rubber works

11. Industry or business

Kelly Springfield Mine

12. Name

Wm F. Griffith

13. Birthplace

Pa.

14. Maiden name

Ida Bell Glover

15. Birthplace

Marysville Pa.

16. Informant

Mrs Agnes Griffith

Address

Mt. Savage Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Mar 15 1948  
(month) (day) (year)

Cemetery or crematory

St. George

Location

Mt. Savage

18. Funeral director

J. R. Rupp

Address

2 Southway, Md.

19.

3/16  
(Date rec'd by registrar)

19

48 Virginia M. D. Smith  
Registrar

RECEIVED

MAR 22 1948

BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

02323

Reg. Dist. No. 4

1. PLACE OF DEATH:  
County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Allegany Hospital  
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State md County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 36 Elder St  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Ronald Dewayne Hall 3. (b) Social Security Number None

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife.....  
7. Birth date of deceased (mo., day, yr.) Feb 23, 1948  
6.(c) If alive, give age..... years  
8. AGE: Years 0 Months 0 Days 24 It less than one day  
..... hrs. .... min.

9. Birthplace Cumberland Allegany Co Md  
(Town, county, and state)  
10. Usual occupation Child

11. Industry or business  
FATHER 12. Name Wm Hall  
13. Birthplace Grant Co. W. Va.  
MOTHER 14. Maiden name Blanche Ketterman  
15. Birthplace Flintstone Creek Pa.

16. Informant Wm Hall  
Address 36 Elder St - Cumberland, Md.  
17. Burial Date thereof March 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Glenlife Brethren Cemetery  
Location Flintstone Md.

18. Funeral director John J. Hafer  
Address Cumberland Md.  
19. March 20, 1948 W.R. Tantz M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH March 17 1948 at 10:16 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 16 1948 to March 17 1948  
and that I last saw him alive on March 17 1948

Immediate cause of death broncho-pneumonia  
Due to bronchitis  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE W.R. Tantz M.D. or other  
Address 59 Green St. Date signed 3-20-48

RECEIVED

MAR 23 1948

BUREAU V. S.



Evidence for change of  
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02324

9

FILM No. G 114 APR 6 1948 CERTIFICATE OF DEATH

Reg. Diat. No. ....

1. PLACE OF DEATH:

County Allegany  
City or town Frostburg Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Mine's Hospital  
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Church St  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

3. (a) FULL NAME

Mary Anna Vanser

3. (b) Social Security Number

213-24-6644

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) Jan 22 - 11/8/1869

8. AGE: Years 79 Months 2 Days 5 It less than one day hrs. min.

9. Birthplace Huffman, Allegany, Md.  
(Town, county, and state)

10. Usual occupation Clk

11. Industry or business Kenny's Cigar Store

12. Name Joseph Vanser

13. Birthplace Frostburg

14. Maiden name Johanna Palmer

15. Birthplace Germany

16. Informant Mrs. Valentine Fisher

Address 22 W 1st St Frostburg Md

17. Burial Date thereof 3-30-1948  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Michael's Cem.

Location Frostburg Md

18. Funeral director Joseph Vanser

Address Frostburg, Md.

19. 3-29 19 48 Mrs. Nancy K. Roe  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 19 48 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 19 Mar 27 19 48

and that I last saw her alive on Mar 27 19 48

Immediate cause of death

Chc. Myocarditis

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE WDM Lane MD

Frostburg Md M. D. or other

Address .....

Date signed 3-29-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

116 1/2 W. 3rd St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 116 1/2 W. 3rd St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Nellie May Hutchinson

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Wilson Hutchinson

7. Birth date of deceased (mo., day, yr.)

May 16, 1885

6. (c) If alive, give age..... years

8. AGE:

Years

62

Months

9

Days

21

If less than one day

hrs.

min.

9. Birthplace

Highland Co., Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Samuel Heavener

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mr. Harry ArbogastAddress 116 1/2 W. 3rd St. Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Mar. 9, 1948  
(month) (day) (year)

Cemetery or crematory

Mt. Zion Cem.

Location

Near Keyser, W. Va.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

March 9, 1948W.R. Trautz, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 7,19 48, at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 15, 1948 to Mar. 7, 1948  
 and that I last saw her alive on Mar. 1, 1948

Immediate cause of death

Myocardial infarction  
Underlying cause: Hypertension (arteriosclerosis)  
 Due to Arteriosclerosis

DURATION

6 wks  
5 yr

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

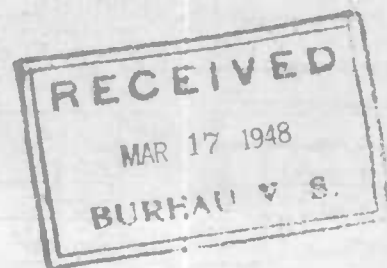
Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Clayton J. Luma  
Cumberland M. D. or other  
 Address..... Date signed 3/9/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Penna. County..... Bedford  
 City or town..... Chaneyville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... R.D. #1 Flintstone  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Blanche Margaret Hymes

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

David Hymes

7. Birth date of

deceased (mo., day, yr.)

Feb. 10, 1908

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

40021

hrs.

min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Amos Huffman

13. Birthplace

Penna.

MOTHER

14. Maiden name

Nellie Rice

15. Birthplace

Cumberland, Md.

16. Informant

Mrs. Nellie Huffman

Address

37 South St. Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 4, 1948  
(month) (day) (year)

Cemetery or crematory

Mt. Herman Cem.

Location

Near Cumberland

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

March 4, 1948W.R. Fautz, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Mar. 1, 1948 at 7:07A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 19, 1948 to March 1, 1948and that I last saw him..... live on..... 19.....

Immediate cause of death

Biliary  
peritonitis  
obstruction  
common duct stone & dense  
adhesions

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Common duct stone Date of op. 2/27/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.R. Fautz M. D. or other  
Cumberland Date signed 3/3/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

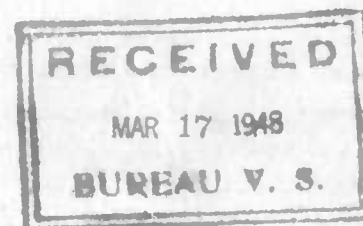
RECEIVED

MAR 9 1948

BUREAU V. S.









PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a

02328

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death 8 1/2 days  
 Hospital, institution, or street address where death occurred:  
Mary's Hospital  
 How long in hospital or institution? 8 1/2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 392 1/2 St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jesse James Jackson

## 3. (b) Social Security Number

705-10-8425

4. Sex

Male

5. Color or race

White

6.(d) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Ellen Rankin Hays

7. Birth date of deceased (mo., day, yr.)

Jan. 7th. 1891

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5727

hrs.

min.

9. Birthplace

Farmington, W. Va.

(Town, county, and state)

10. Usual occupation

Phys. Fitter

11. Industry or business

Belmonte Corp. Inc.

12. Name

Wm. J. Jackson

13. Birthplace

Farmington, W. Va.

14. Maiden name

Susan Berner

15. Birthplace

Farmington, W. Va.

16. Informant

Mr. Jesse J. Jackson

Address

392 1/2 St. Frostburg, Md.

17. Burial

BurialDate thereof 3-17-1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

James G. Gaper

Address

Frostburg, Md.19. 3-16

(Date rec'd by registrar)

19. 48Wm. Stanley K. Roe

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

3-1419. 48 at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-519. 48to 3-1319. 48

and that I last saw him alive on

3-1319. 48

Immediate cause of death

Pneumococcus Meningitis

DURATION

10 d.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank T. Harriet

M. D. or other

Address

59 E. Main St. Frostburg, Md.Date signed 3/16/48

RECEIVED

MAR 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02329

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrsHospital, institution, or street address where death occurred:  
327 Central Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 327 Central Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

James E. Jones4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Elizabeth Jones7. Birth date of deceased (mo., day, yr.) July 3- 18718. AGE: Years 76 Months 8 Days 7 If less than one day9. Birthplace Fredrick Co. Md.  
(Town, county, and state)10. Usual occupation Retired B&O.R. Ry janitor

11. Industry or business

12. Name Jones13. Birthplace Maryland14. Maiden name Henrieth15. Birthplace Maryland16. Informant James JonesAddress 327 Central Ave. Cumberland Md.17. burial Date thereof March 13, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Summer CemeteryLocation Cumberland Md.18. Funeral director Louis Stein, Inc.Address Cumberland Md.19. 3-12 19 48 W.R. Franky, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

705-05-8028

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 48 at 11.55 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him in Dead March 11 19 48

Immediate cause of death

Coronary thrombusDURATION at onceDue to Fracture of the right femur 8 Wks.

Due to

Other conditions Cardiovascular sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

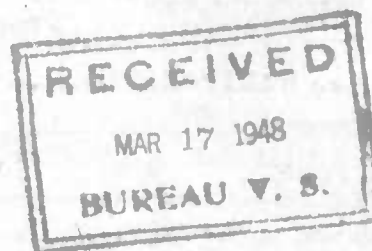
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Accident Date of Jan 2/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) near his homeMeans of injury slipped and fell 14/26/48 also Injured at work?Deputy Medical Examiner - Allegany23. SIGNATURE H.V. Deming M.D. H.V. Deming  
M. D. otherAddress Cumberland Md. Date signed 3-11-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02330

Reg. Dist. No. 4

## 1. PLACE OF DEATH

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Allegany Hospital  
How long in hospital or institution? 3 Days

## 3. (a) FULL NAME

Emma Louise Keiling

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October  
September 25 1947

8. AGE:

Years

Months

Days

If less than one day

524

hrs.

min.

9. Birthplace

Frostburg Allegany Co. Md  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

William Keiling

13. Birthplace

Frostburg Md

MOTHER

14. Maiden name

Edna Skinner

15. Birthplace

Frostburg Md

16. Informant

William Keiling

Address

Frostburg Md RR D #1

17.

(Burial, cremation, or removal, which?)

Burial

Date thereof

3/22/48

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg Md

18. Funeral director

J. J. Burst

Address

Frostburg Md

19.

March 20, 19 48

(Date rec'd by registrar)

W. R. Fautz, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. RR D #1  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 19 48 at 6:45 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 15 19 48 to March 19 19 48and that I last saw him alive on March 19 19 48

Immediate cause of death

virus pneumonia

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE

Elizabeth Brown

M. D. or other

Address La Vale, Md Date signed 3/20/48

RECEIVED

MAR 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 224 Carral St.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Katherine Jean Kelly

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife None

7. Birth date of

deceased (mo., day, yr.) Jan. 23, 1948

8. AGE:

Years

Months

Days

If less than one day

121

hrs.

min.

9. Birthplace Cumberland, Md.  
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name James Kelly13. Birthplace Pa.14. Maiden name Mary Farrell15. Birthplace Md.16. Informant James KellyAddress 224 Carral St.17. Burial Date thereof March 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetary or crematory St. Peters & PaulsLocation Cumberland, Md.18. Funeral director James F. ScarpelliAddress 108 Virginia Ave19. Mar. 10 1948 G. B. Franz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 9 1948 at 12:15P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan - 23 1948 to Mar - 9 1948and that I last saw her Mar - 8 1948Immediate cause of death Intestinal Obstruction complicatedIncomplete Rotation of gut

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. L. BringerCumberland M. D. or other

Address .....

Date signed 3/9/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

**RECEIVED**

MAR 17 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1572

02332

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 15 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland R.F.D. #1  
(If outside city or town limits, write RURAL and give nearest town)Street No. Ed Vole

(If rural, give LOCATION)

2(a) If veteran, name war None

## 3. (a) FULL NAME

John Alfred Kennedy

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Infant

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 20 1948 at 12:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 mn 19 48 to 20 mn 19 48and that I last saw him alive on 20 mn 19 48Immediate cause of death RespiratoryHeart Disease

## DURATION

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) November 14, 19478. AGE: Years Months Days If less than one day  
4 6 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cumberland Allegheny, Maryland  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name William M. Kennedy13. Birthplace Philadelphia, Penna14. Maiden name Florence M. Schmitt15. Birthplace Liberty Corners, New Jersey16. Informant William M. KennedyAddress R.F.D. #1 Cumberland, Md.17. Burial Date thereof March 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest Lawn CemeteryLocation Philadelphia, Penna18. Funeral director John J. NafarAddress Cumberland, Md.19. March 20 1948 W.D. Frank, M.D.  
(Date rec'd by registrar) Registrar

Due to

Due to

Other conditions

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

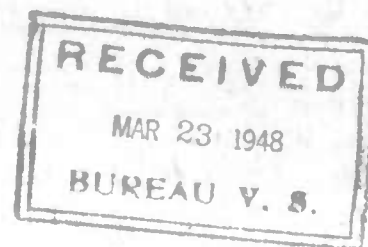
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE

M. D. or other

Address 112 Bedford St. Date signed 20 March



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

107

02333

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... Allegheny  
City or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. Va. County... MonongiaCity or town... Pattersons Creek  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Calvin Junior Kinsble

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.

## 7. Birth date of deceased (mo., day, yr.)

Feb 14, 1949

## 6. (c) If alive, give age. years

## 8. AGE:

Years

Months

Days

If less than one day

1025

hrs.

min.

## 9. Birthplace

Cumberland Allegheny Co, Ind  
(Town, county, and state)

## 10. Usual occupation

Child

## 11. Industry or business

## FATHER

## 12. Name

Leonard Kinsble

## 13. Birthplace

Petersburg, W. Va.

## MOTHER

## 14. Maiden name

Edna Ogden

## 15. Birthplace

Wiley Ford, W. Va.

## 16. Informant

## Address

Leonard KinsblePattersons Creek W. Va.

## 17.

(Burial, cremation, or removal. Which)

Date thereof

March 12, 1948  
(month) (day) (year)

## Cemetery or crematory

Brethren Cemetery

## Location

Flintstone, Ind.

## 18. Funeral director

## Address

John J. HalesCumberland Ind

## 19.

(Date rec'd by registrar)

March 12, 1948  
Walter R. Harts  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 9, 1948 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 9, 1948 to Mar 9, 1948and that I last saw him alive on Mar 9, 1948

Immediate cause of death

Terminal diffuse  
bronchitis

DURATION

1 day

Due to

Bronchopneumonia

Due to

Other conditions

(Include present day within 3 months of death)

Major findings of operations

Emergency tracheostomy  
showed lower respiratory obstruction

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Emmett Jones  
57 Pershing St Cumberland Ind  
Address Date signed Mar 12 '48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02334

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 week  
 Hospital, institution, or street address where death occurred:  
Mines's Hospital  
 How long in hospital or institution? 1 week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MD. County... Allegany  
 City or town... Eckhart Mines  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Harold Klosterman

## 3. (b) Social Security Number

215-20-6879

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

none

## 7. Birth date of deceased (mo., day, yr.)

Sept. 27, 1927

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

2151

hrs.

min.

## 9. Birthplace

Alleg. Co. Eckhart Mines, Md.  
(Town, county, and state)

## 10. Usual occupation

Unemployed

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Henry A. Klosterman

## 13. Birthplace

Red Hill, Alleg. Co., Md.

## 14. Maiden name

Rose Mae Yeider

## 15. Birthplace

Hoffman, Alleg. Co., Md.

## 16. Informant

Henry A. Klosterman

## Address

Eckhart Mines, Md.

## 17.

Burial

## Date thereof

Mar. 24, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

St. Michael's Cemetery

## Location

Frostburg, Md.

## 18. Funeral director

Hafer Funeral Home

## Address

Frostburg, Md.

## 19.

3-23

19

48 Mrs. Nancy N. Roe

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Mar 22 1948 5:10 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 1948 to Mar 22 1948and that I last saw him alive on Mar 21 1948

## Immediate cause of death

Chr. Rheumatic Endocarditis

## DURATION

2 yrs 7?

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Address

M. D. or other

Date signed

3-23-48

RECEIVED

MAR 26 1948

BUREAU V. S.

Evidence for change of  
birth date shown On:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

02335

9

FILM No. G 114 MAR 15 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Allegheny  
City or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 56 yrs.  
Hospital, institution, or street address where death occurred:  
68 Washington St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... 3rd County... Allegheny  
City or town... 68 Washington St.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... Frostburg, Md.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

William Henry Kritzberg

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Margaret E. Kritzberg  
7. Birth date of deceased (mo., day, yr.) Sept 21 - 11/8/67 6. (c) If alive, give age 81 years  
8. AGE: Years 79 Months 5 Days 13 If less than one day 1868 hrs. min.

9. Birthplace... Canonsville, Pa.  
(Town, county, and state)  
10. Usual occupation... Retired  
11. Industry or business... Coal mines

12. Name Henry Kritzberg  
13. Birthplace Allegheny, Pa.  
14. Maiden name Estelle Poterben  
15. Birthplace Scotland, Pa.

16. Informant Mr. East  
Address 141 Center St. Frostburg, Md.  
17. Burial Date thereof 3-6-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Eckhart Cemetery  
Location Eckhart, Md.

18. Funeral director Jacob Vayer  
Address Frostburg, Md.  
19. 3-6 19 48 Mr. Nancy V. Roe  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 19 48 at 4:30 A.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to Mar 4, 1948  
and that I last saw him alive on Mar 3 19 48

Immediate cause of death Hypertension DURATION General  
Cerebral Hemorrhage 4 days

Due to Cerebral Hemorrhage  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

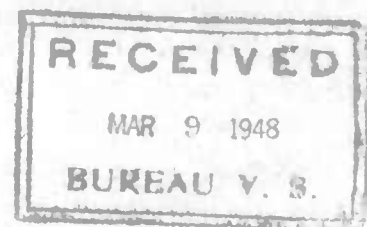
23. SIGNATURE Wm Lane MD M. D. or other  
Address Frostburg, Md. Date signed 3-5-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 65 years

Hospital, institution, or street address where death occurred:

201 Offutt St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 Offutt St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frank Ward Kane

## 3. (b) Social Security Number

75-09-8785

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Zella Campbell Kane

7. Birth date of deceased (mo., day, yr.)

May 16 - 18736. (c) If alive, give age 76 years

8. AGE:

Years

Months

Days

If less than one day

74921

hrs.

min.

9. Birthplace

Winchester Virginia  
(Town, county, and state)

10. Usual occupation

B & O Tool Room Worker

11. Industry or business

Retired

MOTHER

12. Name

John W. Kane

13. Birthplace

Winchester Va.

14. Maiden name

Margaret A. Bolyce

15. Birthplace

Winchester Va.

16. Informant

Mrs Zella C. Kane

Address

201 Offutt Street

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Mar 9, 1948  
(month) (day) (year)

Cemetery or crematorium

Rose Hill Cemetery

Location

Cumberland Md

18. Funeral director

John J. Hafer

Address

Cumberland, Md.

19.

March 9, 1948  
(Date rec'd by registrar)W. H. Hantz, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1948 at 8:00 AM

I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 20, 1948 to March 7, 1948and that I last saw him/her alive on March 6, 1948

Immediate cause of death

Cardio renal

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

T. Bailey Hunter  
M. D. or other

Address

Cumberland MdDate signed 3/9/48

Please sign and  
call 65.

RECEIVED

MAR 17 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02337

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1107 Va. Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1107 Va. Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George Thrall Keller

## 3. (b) Social Security Number

705-09-9847

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Sarah Thomas Keller6. (c) If alive, give age 68 years

7. Birth date of

deceased (mo., day, yr.)

June 6, 1874

8. AGE:

Years

Months

Days

If less than one day

73826

.....hrs. ....min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

B. & O. R.R. Carman

FATHER

12. Name

Josiah Keller

13. Birthplace

Penna.

MOTHER

14. Maiden name

Martha Crawford

15. Birthplace

Unknown

16. Informant

Mrs. Sarah KellerAddress 1107 Va. Ave. Cumberland, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 5, 1948  
(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

March 4, 1948  
(Date rec'd by registrar)W. F. Fautz, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 2,

19

48

at

8:00

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 15, 1948 1948 to Mar 2, 1948and that I last saw him alive on Mar 2, 1948

Immediate cause of death

Coronary thrombosis

DURATION

Due to

arteriosclerosis

Due to

infarction of heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

3/7/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Gorge

RECEIVED

MAR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
of ~~day~~ of death shown  
on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02338

Reg. Dist. No. 8

FILM No. G 114 MAR 23 1948 CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County Allegheny  
City or town Gilmore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Marshall Thomas Lancaster

## 3. (b) Social Security Number

220-10-2057

4. Sex Male 5. Color or race White 6. (a) Single, married, or divorced Married

6. (b) Name of husband or wife Alice Carter Lancaster

6. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1895

8. AGE: Years 52 Months 9 Days 5 If less than one day  
hrs. min.

9. Birthplace Wilton, Md.  
(Town, county, and state)

10. Usual occupation Drumming

11. Industry or business Cover farm - Gilmore

12. Name Ervin F. Lancaster

13. Birthplace Shelley Farm - Md.

14. Maiden name Della Blanche Robison

15. Birthplace Wilton, Md.

16. Informant Mrs. Catherine Russell

Address Barton, Md.

17. Burial Date thereof March 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Northbrook, Md.

18. Funeral director Gr. Eickbush

Address Conacoquina, Md.

3/8 48 Jannette M. Pool

19. (Date rec'd by registrar) 19 48 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Gilmore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1  
(If rural, give LOCATION)

2. (a) If veteran, name war 1

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 48 at 19 48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 3/1 48

Immediate cause of death Acute bronchial asthma

Due to allergy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically:

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Drup M.D.

Address Longsoring, Md. Date signed 3/8/48

RECEIVED

MAR 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02339

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg, Route 1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all his life  
 Hospital, institution, or street address where death occurred:  
Route 1, Frostburg  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Frostburg, Route 1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Borden Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Ernest Melvin Layman

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mary Layman

## 7. Birth date of deceased (mo., day, yr.)

August 27, 1878(c) If alive, give age 66 years

## 8. AGE:

Years

Months

Days

If less than one day

69626

hrs.

min.

## 9. Birthplace

Frostburg, Allegany, Md.  
(Town, county, and state)

## 10. Usual occupation

retired

## 11. Industry or business

mail carrier

## FATHER

## 12. Name

George Layman

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Annie L. Crowe

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Charles Norris

## Address

Baltimore Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Mar. 27, 1948  
(month) (day) (year)

## Cemetery or crematory

Allegany Cemetery

## Location

Frostburg Md.

## 18. Funeral director

J. R. Quist

## Address

Frostburg Md.

## 19.

3-27

(Date rec'd by registrar)

19.

48Mrs. Nancy H. Rue

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Mar 24 1948 at 1:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 1948 to Mar 24 1948and that I last saw him alive on Mar 23 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 hrs

Due to

Hypertensionseveral  
years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. O. McFarlane M.D.  
Frostburg Md. Date signed 3-26-48



**RECEIVED**

MAR 29 1948

**BUREAU V. S.**



Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02340

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 78-2-0  
 Hospital, institution, or street address where death occurred 832 S. Turner Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 832 Turner Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Anna Catherine Long

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Harry H. Long  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 30 1870  
 8. AGE: Years 78 Months 2 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland Ind.  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business at home  
 12. Name John H. Renschlein  
 13. Birthplace Cumberland Ind.  
 14. Maiden name Elizabeth Bachman  
 15. Birthplace Cumberland Ind.

16. Informant Mrs Scott Street  
 Address Cumberland  
 17. Burial Date thereof Apr 2 48  
 (Burial, cremation, or removal, etc.) (month) (day) (year)  
 Cemetery or crematory St Lukes Cem.  
 Location Cumberland Ind.  
 18. Funeral director Louis Stein Inc  
 Address Cumberland

19. April 2 48 W. J. Fautz, M.D.  
 (Date rec'd by registrar) Registrar

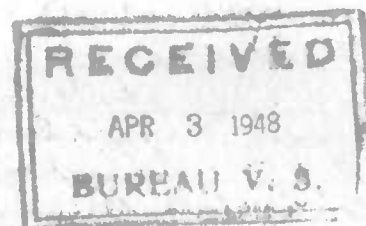
## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 1948 to March 30 1948  
 and that I last saw him alive on March 20 1948

Immediate cause of death Cerebral hemorrhage DURATION 1/2 minute  
 Due to Hypertensive cardio-vascular disease with 20 years  
 Due to cerebral circulatory infarct 1 mo.  
 Other conditions He Feb 21 had cerebrovascular accident which left no residual damage.  
 (Include pregnancy within 8 months of death)  
 Major findings of operations No  
 Date of op. No  
 Autopsy results No  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Javelle G. Weisman MD M. D. or other  
 Address 122 Bedford St, Cumberland Date signed March 31, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

110 West 3rd St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 West 3rd St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Elizabeth Lechlitter

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Wm. H. Lechlitter6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) July 3, 18898. AGE: Years Months Days It less than one day  
58 8 2 .....hrs. ....min.9. Birthplace Cumberland, Md.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name James Moore13. Birthplace Va.14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Wm. H. LechlitterAddress 110 W. 3rd. St. Cumberland, Md.17. Burial Date thereof Mar. 8, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. March 7, 1948 W.R. Frantz, M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5, 1948 at 5 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1, 1948 to Mar. 5, 1948 and that I last saw her alive on Mar. 4, 1948Immediate cause of death TraumaUnderlying cause HypertensionDue to Cerebral HemorrhageDue to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clayton J. Smith M. D. or otherAddress Cumberland Date signed 3/5/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1948

BUREAU V S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1628

02342

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 MonthsHospital, institution, or street address where death occurred:  
Allegany County InfirmaryHow long in hospital or institution? 15 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Martha W. Malloy

## 3. (b) Social Security Number

None

|                         |                                  |                                                               |
|-------------------------|----------------------------------|---------------------------------------------------------------|
| 4. Sex<br><u>Female</u> | 5. Color or race<br><u>White</u> | 6. (a) Single, married, widowed, or divorced<br><u>Single</u> |
|-------------------------|----------------------------------|---------------------------------------------------------------|

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) February 22 1866

|                            |                    |                   |                                            |
|----------------------------|--------------------|-------------------|--------------------------------------------|
| 8. AGE: Years<br><u>82</u> | Months<br><u>0</u> | Days<br><u>20</u> | If less than one day<br>.....hrs. ....min. |
|----------------------------|--------------------|-------------------|--------------------------------------------|

9. Birthplace Mt. Savage, Allegany Co. Maryland  
(Town, county, and state)10. Usual occupation House11. Industry or business "12. Name Thomas Malloy13. Birthplace Ireland14. Maiden name Ellen Logsdon15. Birthplace Penna.16. Informant Miss Nellie TanseyAddress Mt. Savage, Md.17. Burial Date thereof 3/15/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Patricks CemeteryLocation Mt. Savage, Md.18. Funeral director J.J. DurstAddress Frostburg, Md.19. 3-13 71 J.R. Brant MD  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 48 at 8-30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to March 12 48and that I last saw her alive on March 9 19 48

Immediate cause of death \_\_\_\_\_ DURATION

Centr. myocardial failure 2.5 min.Due to due to senility

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Mens of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Arthur F. Jones M.D.Address 110 S. Centre St. Date signed 3-13-48

RECEIVED

MAR 17 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02343

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 daysHospital, institution, or street address where death occurred:  
MEMORIAL HOSPITALHow long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. #100 W. SECOND ST.  
(If rural, give LOCATION)

2.(d) If veteran, name war

## 3. (a) FULL NAME

McCORMICK, ANNA MRS.

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITEWIDOWED6. (b) Name of husband or wife McCORMICK, JOSEPHDECEASED6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) 11/19/818. AGE: Years Months Days If less than one day  
66 3 12 hrs. min.9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name MILLER, J.W.13. Birthplace MD.14. Maiden name FAUBLE, ELISABETH15. Birthplace MD.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof 3/4/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St Lukes CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. March 4, 1948 W.R. Tantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 1, 1948 at 3:50 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
MAR. 1 1948, to MAR. 1 1948and that I last saw h. ev. alive on MAR. 1 1948Immediate cause of death NASAL HEMORRHAGE DURATION 4 DAYSDue to HYPERTENSION ?Due to ARTERIOSCLEROSIS ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

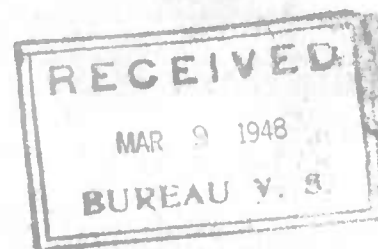
Means of injury Injured at work?

23. SIGNATURE Emmett Jones M. D. or otherAddress 50 Pershing St Cumberland Date signed 3-1-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02344

Reg. Dist. No. *14*

## 1. PLACE OF DEATH:

County *Allegany*  
 City or town *Corriganville, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *25 years*  
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State *Maryland* County *Allegany*  
 City or town *Corriganville*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Frank Benjamin Mc Cray*

## 3. (b) Social Security Number

Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*  
 6. (b) Name of husband or wife *Grace Kraus*

6. (c) If alive, give age. years  
 7. Birth date of deceased (mo., day, yr.) *August 23, 1886*

8. AGE: Years *61* Months *6* Days *21* If less than one day  
 hrs. min.

9. Birthplace *Everett, Pennsylvania*  
 (Town, county, and state)

10. Usual occupation *Store proprietor*

## 11. Industry or business

12. Name *no record*

13. Birthplace

14. Maiden name *no record*

15. Birthplace

16. Informant *Howard Mc Cray*

Address *Corriganville, Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *March 17, 1948*  
 (month) (day) (year)

Cemetery or crematory *Greenmount*

Location *Cumberland, Md.*

18. Funeral director *Harvey H. Ziegler*

Address *Hyndman, Pa.*

19. *3-16-48 J. P. Wolf*

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 14, 1948* at *7:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *January 1, 1948* to *March 14, 1948*  
 and that I last saw him alive on *March 13, 1948*

Immediate cause of death *Pulmonary Tuberculosis*

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *William E. Mosley, Md.*

M. D. or other

Address *Mt. Savage, Md.*

Date signed *3-16-1948*

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02345

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Mt. Savage  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Mt. Savage  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Catherine Louise McDermitt

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed

## 6.(b) Name of husband or wife

Augustine McDermitt

## 7. Birth date of deceased (mo., day, yr.)

January 6, 1870

## 6.(c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

78222

hrs.

min.

## 9. Birthplace

Mt. Savage, Allegany, Md.

(Town, county, and state)

## 10. Usual occupation

housewife

## 11. Industry or business

home

FATHER  
MOTHER

## 12. Name

George Malloy

## 13. Birthplace

New York

## 14. Maiden name

Mary Dull

## 15. Birthplace

Connellsville, Pa.

## 16. Informant

Kathleen McDermitt,

## Address

Mt. Savage, Md.

## 17.

Burial

## Date thereof

Mar. 31 '48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

St. Patrick's Cemetery,

## Location

Mt. Savage, Md.

## 18. Funeral director

J. R. Durst,

## Address

Frostburg, Md.

## 19.

March 30, 1948

(Date rec'd by Registrar)

Doronica McDermitt

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1948, 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to March 28, 1948  
 and that I last saw him alive on March 26, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Hypertension Heart Disease

Due to

4 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

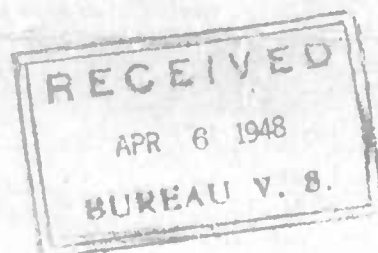
Means of injury..... Injured at work?

23. SIGNATURE

F. Allen G. Manning

M. D. or other

Address..... Date signed March 30, 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

02346

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 3 min.  
 Hospital, institution, or street address where death occurred:  
Pluma's Restaurant, 731 Va. Ave  
 How long in hospital or institution? Dead on arrival at Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 16 Laing Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Martin Joseph Mc Guire

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Beatrice Curran Mc Guire7. Birth date of deceased (mo., day, yr.) Oct. 7- 18838. AGE: Years Months Days If less than one day  
64 5 20 hrs. min.9. Birthplace Piedmont W. Va.  
(Town, county, and state)10. Usual occupation B&O R.R. mechanic11. Industry or business B&O RR12. Name Thomas Mc Guire13. Birthplace Md14. Maiden name Mary Murphy15. Birthplace Md16. Informant Thomas V. McGuire (brother)Address Westernport Md.17. Burial & Removal Date thereof 3/30/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter Catholic Ceme.Location Westernport, Md18. Funeral director Louis Stein Inc.Address Cumberland, Md19. March 29, 1948 W.R. Trautz, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

705-09-9506

## MEDICAL CERTIFICATION about

20. DATE OF DEATH March 27 19 48 at 3.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead March 27 19 48Immediate cause of death Coronary occlusion DURATION at once

Due to

Due to

Other conditions Alcoholic at times about 2(Include pregnancy within 3 months of death) weeks  
spree.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany23. SIGNATURE H.V. Deming M.D. N.V. Deming M.D.  
M. D. ofAddress Cumberland Md. Date signed 3-27-48

RECEIVED

APR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02347

Reg. Dist. No. 8

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Gonaconing  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Annex Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Gonaconing  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Annex St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

James M<sup>r</sup> McIntyre, Sr.

## 3. (b) Social Security Number

217-03-2160

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male White Married

6. (b) Name of husband or wife..... Nellie Russell McIntyre

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... 67 years

Jan 4, 1874

8. AGE: Years..... Months..... Days..... It less than one day.....

74 1 28 hrs. min.

9. Birthplace.....

Gonaconing, Ind.

10. Usual occupation.....

Local Mines

11. Industry or business.....

Ind. Coal Co.

12. Name.....

David M. McIntyre

13. Birthplace.....

Scotland

14. Maiden name.....

Elizabeth Hartley

15. Birthplace.....

Scotland

16. Informant.....

Russell McIntyre

Address.....

Gonaconing, Ind.

17. Burial, cremation, or removal, Which?..... Date thereof.....

Burial May 5, 1948

Cemetery or crematory.....

Oak Hill Cemetery

Location.....

Gonaconing, Ind.

18. Funeral director.....

J. M. Eickhoff

Address.....

Gonaconing, Ind.

19. Date rec'd by registrar.....

Mar 5 48

20. Signature.....

Janette M. Coal

Registar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3 / 2 1948 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 / 17 1948 to 3 / 2 1948

and that I last saw him alive on 3 / 2 1948

Immediate cause of death.....

Heart block and

auricular fibrillation

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Paul Eugene Dye, M.D.

Address.....

Gonaconing, Ind.

Date signed.....

3/5/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County Allegany  
 City or town Luke  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 38 years  
 Hospital, institution, or street address where death occurred:  
Mullen Ave  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Luke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Mullen Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war —

## 3. (a) FULL NAME

Lillian Roberta Overton

## 3. (b) Social Security Number

216-07-9410

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Negro Divorced

6. (b) Name of husband or wife

—

7. Birth date of deceased (mo., day, yr.) November 19, 1900

8. AGE: Years Months Days If less than one day

47 3 16 hrs. min.9. Birthplace Baltimore, Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Cook11. Industry or business West Vaco Club12. Name John Overton13. Birthplace Virginia14. Maiden name Lucy Johnson15. Birthplace Virginia16. Informant Margaret HaddellAddress 145 Keosport, Penna17. Burial Date thereof March 8, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Walton CemeteryLocation Westport, Md18. Funeral director E. Elsworth S. BaalAddress Westport, Md19. March 8 19 48 Raymond M. M...  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 48 at — M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 42 to March 5 19 48and that I last saw her alive on March 5 19 48Immediate cause of death Coronary Thrombosis DURATIONDue to ArteriosclerosisDue to Sudden deathOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE P.E. Berry M.D. M. D. or other —Address Piedmont W Va Date signed 3/6/48

RECEIVED

MAR 9 1948

BUREAU V. S.

Within corporate records

Evidence for addition of wife's age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02349

FILE No. G 11 APR 7 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:  
County... Allegany  
City or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Allegany Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... Maryland County... Allegany  
City or town... Rural Old Town  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... R.D. 1  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

3. (a) FULL NAME  
John W. Parker

3. (b) Social Security Number  
705-10-8708

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mabel Shrout Parker  
7. Birth date of deceased (mo., day, yr.) October 19, 1872  
8. AGE: Years 75 Months 4 Days 18 If less than one day  
hrs. min.

9. Birthplace Lost River, W. Va.  
(Town, county, and state)  
10. Usual occupation Retired

11. Industry or business W. Md. R.R. CO.

FATHER 12. Name George W. Parker  
13. Birthplace Petersburg, W. Va.

MOTHER 14. Maiden name Mary Wilson  
15. Birthplace Lost River, W. Va.

16. Informant Mrs. Mabel Parker  
Address Old Town, Md.

17. Burial Date thereof Mar. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Old Town Cem.  
Location Old Town, Md.

18. Funeral director Charles L. George  
Address Cumberland, Md.

19. Mar. 10 19 48 W.R. Zantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7, 1948 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1948 to March 7, 1948  
and that I last saw him alive on March 7, 1948

Immediate cause of death Hypertension C.V. Wilson years  
DURATION

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler, M.D.  
M. D. or other

Address 41 Green St. Cumberland, Md. Date signed March 9, 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

02350

8

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Woodland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?..... ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Woodland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... ✓  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Halter Tyler Patterson

## 3. (b) Social Security Number

213-09-6447

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Mary Elizabeth Miller Patterson  
 7. Birth date of deceased (mo., day, yr.)..... April 11, 1881  
 8. AGE: Years..... 66 Months..... 11 Days..... 1 If less than 600 day..... hrs. .... min.

9. Birthplace..... Scotland  
 (Town, county, and state)  
 10. Usual occupation..... Check Reishman at Mine  
 11. Industry or business..... Jenkins Coal Co.  
 12. Name..... Adam Patterson  
 13. Birthplace..... Scotland  
 14. Maiden name..... Christine W. Decker  
 15. Birthplace..... Scotland

16. Informant..... Mrs. Halter Patterson  
 Address..... Woodland

17. Burial..... ✓ Date thereof..... March 14, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Allegany Cemetery  
 Location..... Frostburg, Md.

18. Funeral director..... M. E. Pichhorn  
 Address..... Conowingo, Md.

19. 3/13 1948 Janette M. Coal  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 12 1948, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 12 1948, to March 12 1948,  
 and that I last saw him alive on March 12 1948.

Immediate cause of death..... Coronary Occlusion DURATION..... 3 hours

Due to..... ✓

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... A. E. Galtner M.D.

Address..... Frostburg, Md. Date signed..... 3/13/48

RECEIVED

MAR 19 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02351

## 1. PLACE OF DEATH:

County Allegany  
 City or town Chamberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 83-3-2  
 Hospital, institution, or street address where death occurred  
Allegany Co Infirmary  
 How long in hospital or institution? 10 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Chamberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. See 14 Euclid Place  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Herry Pfitzenmeyer

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 8 1864 6. (c) If alive, give age years

8. AGE: Years 83 Months 3 Days 2 If less than one day hrs. min.

9. Birthplace Chamberland Ind.  
 (Town, county, and state)

10. Usual occupation Laborer - general

11. Industry or business

12. Name Christopher Pfitzenmeyer13. Birthplace Germany14. Maiden name Lybraut15. Birthplace Ind.16. Informant Wm Seiler17. Burial Date thereof Mar 13 '48  
 (Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory St Lukes Cem.Location Chamberland18. Funeral director Yonis Stein Inc.Address Chamberland19. 3-13-48 19 48 W.R. Kautz, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 48 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 19 46 to Mar 10 19 48and that I last saw him alive on Mar 9 19 48

Immediate cause of death

DURATION

Myocardial failure due to 4 wksDue to Chr. myocarditisDue to Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.Address 110 S. Centre St Date signed 3-12-48



RECEIVED

MAR 17 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02352

Reg. Dist. No. 8

### 1. PLACE OF DEATH:

County Allegany  
City or town Lonaconing  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 72 years  
Hospital, institution, or street address where death occurred Stateville  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Lonaconing  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Stateville  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Emma McMillan Porter

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife John E. Porter  
7. Birth date of deceased (mo., day, yr.) December 31, 1875  
6. (c) If alive, give age 71 years  
8. AGE: Years 72 Months 2 Days 6 If less than one day  
hrs. min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1948 at 11 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/6 1948 to 3/7 1948  
and that I last saw her alive on 3/6 1948

Immediate cause of death Congestive heart failure DURATION

9. Birthplace Lonaconing, Allegany Co., Md.  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name James M. McMillan  
13. Birthplace Pennsylvania

14. Maiden name Annie Myers  
15. Birthplace Mt. Savage, Md.

16. Informant John Porter

Address Lonaconing, Md.

17. Burial Date thereof Mar. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Lonaconing, Md.

18. Funeral director M. E. Eickhorn

Address Lonaconing, Md.  
19. Mar 10 1948 Registrar  
(Date rec'd by registrar)

Due to Hypertensive - Arteriosclerosis  
Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dry, M.D. M. D. or other

Address Lonaconing, Md. Date signed 3/8/48

MARGIN RESERVED FOR BINDING

VS-415 9-45-15M

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 19 1948

BUREAU V. S.

Outside of  
City Limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

02353

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Near Cumberland Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 53 Yrs 1 Mo 11 Days  
 Hospital, institution, or street address where death occurred:  
Bedford Road, R. F. D. #3  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Near Cumberland Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Bedford Road, R. F. D. #3  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Myrtle Mae Porter

## 3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Ernest C. Porter  
 6.(c) If alive, give age 64 years  
 7. Birth date of deceased (mo., day, yr.) January 22 1895  
 8. AGE: Years 53 Months 1 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland, Allegany Co., Maryland  
 (Town, county, and state)  
 10. Usual occupation House  
 11. Industry or business  
 12. Name Nathan Johnston  
 13. Birthplace Cumberland, Md.  
 14. Maiden name Mayme Seaders  
 15. Birthplace Cumberland, Md.

16. Informant Ernest C. Porter  
 Address Bedford Road, Cumberland, Md.  
 17. Burial Date thereof 3/6/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Zion Memorial Park Cemetery  
 Location Cumberland, Md.  
 18. Funeral director William H. Kight  
 Address Cumberland, Md.

19. March 5 19 48 W.R. Frank, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 48 at 6-45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to March 3 19 48  
 and that I last saw her alive on March 2 19 48

Immediate cause of death Carcinoma DURATION

Due to Primary adn. Carcinoma of breast

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

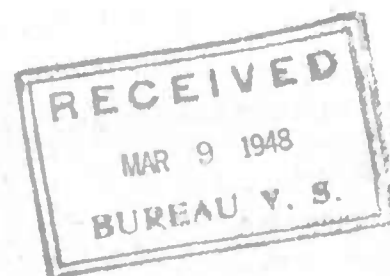
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Bailey Hunter M.D. M. D. or other

Address Cumberland Md Date signed 3/4/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 hours  
 Hospital, institution, or street address where death occurred:  
Miners Hospital  
 How long in hospital or institution? 3 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Midland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ---

## 3. (a) FULL NAME

Mary S. Linnor Preston

## 3. (b) Social Security Number

---4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Chas. D. Preston7. Birth date of deceased (mo., day, yr.) April 22, 1906 6. (c) If alive, give age 4 years8. AGE: Years 41 Months 10 Days 10 If less than one day hrs. min.9. Birthplace Shaft, Allegany Co., Md. (Town, county, and state)10. Usual occupation Housework11. Industry or business Own home12. Name Benjamin Linnor13. Birthplace Shaft, Md.14. Maiden name Barbara Knapp15. Birthplace Griller Mine, Midland, Md.16. Informant Mrs. Ethel SlingloffAddress Frostburg, Md.17. Burial Mar 6, 1948 Date thereof (month) (day) (year)Cemetery or crematory Allegany Cemetery,Location Frostburg, Md.18. Funeral director M. E. EichhornAddress Lonaconing, Md.19. 3-6 19 48 Mrs. Nobby X. Roe (Date rec'd by registrar) (Year) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 19 48 at 8 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/2 19 48 to 3/2 19 48and that I last saw her alive on 3/2 19 48Immediate cause of death Cerebral Hemorrhage

## DURATION

Due to HypertensionOther conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

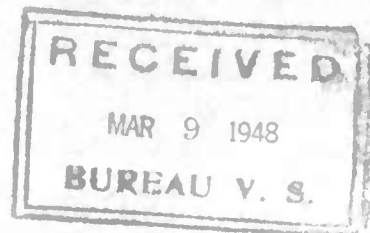
Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dye, M.D. M. D. or otherAddress Lonaconing, Md. Date signed 3/5/48



DR. WILSON

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County.....ALLEGANY  
 City or town.....CUMBERLAND, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....45 Yrs 8 Mo 23 Days  
 Hospital, institution, or street address where death occurred:  
 MEMORIAL Hospital  
 How long in hospital or institution?.....3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY  
 City or town.....CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 129 MAPLE ST.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

GREYNOLD REUSCHEL

## 3.(b) Social Security Number

212-18-1171

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE SEPARATED

6.(b) Name of husband or wife.....JOHN REUSCHEL

7. Birth date of deceased (mo., day, yr.).....JUNE 13 1902  
 6.(c) If alive, give age.....48 years

8. AGE: Years Months Days If less than one day  
 45 8 23 .....hrs. ....min.

9. Birthplace.....MARYLAND Cumberland  
(Town, county, and state)

10. Usual occupation.....Spinner

11. Industry or business.....Celanese Corporation

12. Name.....CHARLES CRAWFORD

13. Birthplace.....W.VA.

14. Maiden name.....HERSHMAN, ALFRETA

15. Birthplace.....W.VA.

16. Informant.....Mrs Raymond Snyder

Address 444 Columbia St., Cumberland, Md.

17. Burial Date thereof 3/9/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Rose Hill Cemetery

Location.....Cumberland, Md.

18. Funeral director.....William H. Kight

Address.....Cumberland, Md.

19. March 9, 1948 W.F. Tantz, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....MARCH 6 1948 at 11:15A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1948, March 6, 1948

and that I last saw him alive on March 6, 1948

Immediate cause of death.....toxemia &amp; shock DURATION

following

cholecystectomy 1 day

Due to drainage common duct.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Date signed 3-7-48

RECEIVED

MAR 17 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02356

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 73-7-0  
 Hospital, institution, or street address where death occurred:  
19 Valley St  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 19n Valley St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Samuel Lawrence Reynolds

## 3. (b) Social Security Number

705-07-9543

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white widower6. (b) Name of husband or wife Mary Pendegast7. Birth date of deceased (mo., day, yr.) Aug. 8-18748. AGE: Years Months Days If less than one day  
73 7 0 ..... hrs. .... min.9. Birthplace Cumberland Md.  
(Town, county, and state)10. Usual occupation retired B&O.R.Ry. foreman

## 11. Industry or business

12. Name Zachariah Taylor Reynolds13. Birthplace Md.14. Maiden name Mary Magdelene Gift15. Birthplace Md.16. Informant Mrs Margaret O'RourkeAddress Cumberland17. Burial Date thereof Nov 12 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Patricks CemLocation Cumberland18. Funeral director John Stein IncAddress Cumberland19. Mar 10 19 48 Walter R. Priddy, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 48 at 10.30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him in Dead March 8 19 48

Immediate cause of death.....

Chronic myocarditis DURATION several  
years

Due to.....

Due to.....

Other conditions Cardiovascular & renal  
sclerosis also hypertention  
(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Medical Examiner injured at work Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or D. O.Address Cumberland Md. Date signed 3-9-48

RECEIVED

MAR 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 75 Years  
 Hospital, institution, or street address where death occurred:  
Allegheny County Infirmary  
 How long in hospital or institution? Six Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 157 Polk St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Rose B. Robb

## 3. (b) Social Security Number

None

|                                                                     |                                  |                                                               |
|---------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------|
| 4. Sex<br><u>Female</u>                                             | 5. Color or race<br><u>White</u> | 6. (a) Single, married, widowed, or divorced<br><u>Single</u> |
| 6. (b) Name of husband or wife                                      |                                  |                                                               |
| 7. Birth date of deceased (mo., day, yr.)<br><u>January 16 1867</u> |                                  |                                                               |
| 8. AGE: Years<br><u>81</u>                                          | Months<br><u>2</u>               | Days<br><u>12</u><br>hrs. min.                                |

6. (c) If alive, give age years

9. Birthplace Frostburg, Allegheny Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation Registered Nurse  
 11. Industry or business Nursing  
 12. Name George Robb  
 13. Birthplace Germany  
 14. Maiden name Sarah Ann Rice  
 15. Birthplace Maryland

16. Informant Harry Hanson  
 Address Frostburg, Md.  
 17. Burial Date thereof 3/30/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Allegheny Cemetery  
 Location Frostburg, Md.  
 18. Funeral director William H. Kight  
 Address Cumberland, Md.

19. March 29 1948 W.R. Taub M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 48 at 9-25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 1 19 48 to Mar 28 19 48  
 and that I last saw him alive on Mar 26 19 48

Immediate cause of death myocardial failure DURATION 3 1/2 days

Due to Chronic myocarditis

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 1105 Centre St. Date signed 3-29-48

RECEIVED

APR 3 1948

BUREAU V. S.

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

02358

1. PLACE OF DEATH:

County Allegany

City or town Allegany Grove, Cumberland Ma.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred  
Near Cumberland, Rural

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Allegany Grove, Cumberland Ma.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Cumberland, Rural  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William B. Robb

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Willie Wilson Robb

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1871

8. AGE: Years Months Days It less than one day

76 10 20 hrs. min.

9. Birthplace Cumberland, Md.  
(Town, county, and state)

10. Usual occupation Gas & Oil Business Operator

11. Industry or business

12. Name Charles Robb

13. Birthplace Scotland

14. Maiden name Josephine Wolfe

15. Birthplace Maryland

16. Informant Mrs. Willie Robb

Address R.D.#1 Cumberland, Md.

17. Burial Date thereof Mar. 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. March 7, 1948 W.L. Kautz, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1948 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead March 5, 1948

Immediate cause of death

Angina pectoris

DURATION  
about  
2 years

Due to

arteriosclerosis

several  
years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

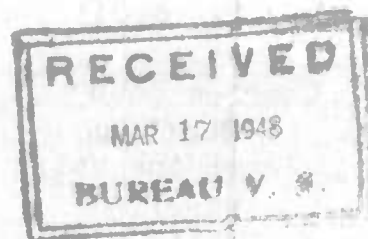
23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
Cumberland Md. Date signed 3.5.48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr P. R. Wilson

Reg. Dist. No. 6

02359

## 1. PLACE OF DEATH:

County Barton  
 City or town Allegany  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 71 years  
 Hospital, institution, or street address where death occurred:  
State Road  
 How long in hospital or institution? - - - - -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Barton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Eutaw Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war - - - - -

## 3. (a) FULL NAME

DAVID GEORGE ROBERTSON

## 3. (b) Social Security Number

181-10-8073

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced  
~~Single~~ MARRIED

6. (b) Name of husband or wife Violet Robertson  
 6. (c) If alive, give age - - - - - years

7. Birth date of deceased (mo., day, yr.) December 16, 1876

8. AGE: Years 71 Months 3 Days 9 If less than one day  
 .....hrs. ....min.

9. Birthplace Lonaconing, Allegany, Maryland  
 (Town, county, and state)  
Janitor

10. Usual occupation Paper Mill

11. Industry or business

12. Name George D. Robertson

13. Birthplace Scotland

14. Maiden name Katherine Symons

15. Birthplace England

16. Informant Joseph Robertson  
Barton, Maryland

17. Burial Burial Date thereof March 27, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery  
Moscow, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. Mar. 27 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948 at 11:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Feb 10 1948 to Mar 23 1948  
 and that I last saw him alive on Mar. 24 1948

Immediate cause of death Pulmonary Edema DURATION 1 Day

Due to Chronic Hypertension and Myocardial Degeneration Not specified as thrombotic 2 Weeks

Other conditions Asthma 2 Weeks

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None  
 Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson, M.D. M. D. or other

Address Piedmont, W. Va. Date signed 3-26-48

RECEIVED

MAR 29 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits  
67.00

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

02360

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? Approximately 10 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 852 Camden Avenue,  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MR. GEORGE J. SCHRAMM

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Viola Lingo

7. Birth date of

deceased (mo., day, yr.)

January 21, 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

80114

hrs.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name

John C. Schramm

13. Birthplace

Germany

14. Maiden name

Wilhelmina

15. Birthplace

Germany16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial  
(Burial, cremation, or removal, Which?)Date thereof Mar 7 48  
(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc.

Address

Cumberland19. March 6 1948  
(Date rec'd by registrar)W. F. Williams, M.D.  
Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1948 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

3-5-48 19 48 to 3-5-48 19 48  
end that I last saw him alive on 3-3-48 19 48

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

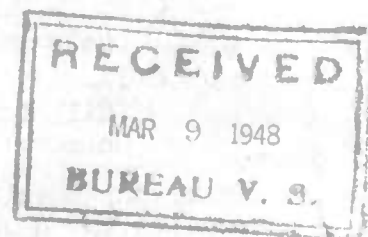
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Cumberland Date signed 3/6/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

02361

## 1. PLACE OF DEATH:

County AlleghenyCity or town Marion  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County AlleghenyCity or town Marion  
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. Box 202 Franklin, W. Va.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles Scott

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Matilda Penix

## 7. Birth date of deceased (mo., day, yr.)

Jan - 11 - 1862

## 6. (c) If alive, give age

78 years

## 8. AGE:

Years

Months

Days

If less than one day

8623

hrs.

min.

## 9. Birthplace

Tracy, Kentucky  
(Town, County, and State)

## 10. Usual occupation

Retired Coal Miner

## 11. Industry or business

MOTHER FATHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

19 48William M. Demitt  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 14<sup>th</sup> 19 48 at 9:30 P. M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10 19 48 to March 14 19 48  
and that I last saw him alive on March 14 19 48

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

3 days

## Due to

Vascular Hypertension

## Due to

## Other conditions

Myocarditis & Chronic  
Nephritis  
(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

William E. Mosley M.D.  
M. D. of

## Address

101 Savage Rd.

Date signed

3/16-1948

RECEIVED

MAR 22 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02362

## 1. PLACE OF DEATH:

County AlleganyCity or town Chamberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 72 yrs

Hospital, institution or street address where death occurred:

Sylvan Retreat  
30 yrs

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Chamberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Hills Creek Ave

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Anna A Sell

## 3. (b) Social Security Number

none4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) April 10 18758. AGE: Years 72 Months 11 Days 7 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Chamberland Ind  
(Town, county, and state)10. Usual occupation none

## 11. Industry or business

12. Name Lawrence A Sell13. Birthplace Germany14. Maiden name Margaret Smith15. Birthplace Germany16. Informant Miss Emma SellAddress Chamberland17. Burial Date thereof March 19 48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St Peter & Pauls ChLocation Chamberland18. Funeral director Louis Stein IncAddress Chamberland19. March 18, 19 48 W. L. Gantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 48 at 9 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Mar 17 19 48and that I last saw her alive on Mar 15 19 48

Immediate cause of death \_\_\_\_\_

Acute myocardial failure

Due to \_\_\_\_\_

due to Senility

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Arthur F. Jones M.D.Address 110 S. Centre St. Date signed 3-18-48

RECEIVED

MAR 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02363

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Week  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution? 1 Week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State W. Va. County Mineral  
 City or town Rural Ridgeley, W. Va.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.D.# 1.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war ✓

## 3. (a) FULL NAME

Sophia Jane Senn

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Hanson J. Senn  
 7. Birth date of deceased (mo., day, yr.) Aug. 2, 1887  
 8. AGE: Years 60 Months 7 Days 28 It less than one day hrs. min.

9. Birthplace Hampshire Co. W. Va.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

FATHER 12. Name Adam Abe  
 13. Birthplace W. Va.

MOTHER 14. Maiden name Martha Moreland  
 15. Birthplace W. Va.

16. Informant Mr. Oliver W. Senn  
 Address R.D.#1 Ridgeley, W. Va.

17. Burial Apr. 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Abe Cemetery  
 Location Old Furnace, W. Va.

18. Funeral director Charles L. George  
 Address Cumberland, Md.

19. April 1, 1948 W. H. Fawcett, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30, 1948 at 7:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1948 to March 30, 1948  
 and that I last saw her alive on March 30, 1948

Immediate cause of death Portal Carcinoma years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Portal carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D. or other

Address 411 E. ... Date signed March 31, 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 3 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02364

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 2 min.  
 Hospital, institution, or street address where death occurred:  
111 Weber St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 111 Weber St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Baby Girl Shrout

## 3. (b) Social Security Number

None

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

6. (c) If alive, give age. years

## 7. Birth date of

deceased (mo., day, yr.) 3.23-48

## 8. AGE:

Years

Months

Days

If less than one day

0000

hrs.

2

min.

9. Birthplace Cumberland, Allegany Co. Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

12. Name Everett W. Shrout13. Birthplace Morgantown W.Va.

## MOTHER

14. Maiden name Freda Loretta Potts15. Birthplace Flintstone Md.16. Informant ParentsAddress 111 Weber St. Cumberland Md.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof 3/24/48

(month) (day) (year)

Cemetery or crematory High Ex. Burial HomeLocation Cumberland Md.18. Funeral director William H. KightAddress Cumberland Md.March 24, 1948

(Date rec'd by registrar)

W.R. Drutz, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 48 at 10:42 <sup>P</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 23 19 48 to 3.23 19 48and that I last saw her alive on March 23 19 48

Immediate cause of death

Premature separation of placenta.

DURATION

about 2 min.

Due to

Due to

Other conditions Mother stated she had uterine bleeding, about 2 weeks  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 3-24-48

**RECEIVED**

MAR 30 1948

**BUREAU V. S.**





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

02366

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or other place where death occurred:

Memorial HospitalHow long in hospital or institution? Dead on arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County MineralCity or town Wiley Ford  
(if outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

LOUIS M. STALLINGS

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Feb. 25 18848. AGE: Years Months Days If less than one day  
64 0 12 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Spring Gap, Md.  
(Town, county, and state)10. Usual occupation Trucker11. Industry or business own12. Name Louis Stallings13. Birthplace Maryland14. Maiden name Anna Twigg15. Birthplace Md.16. Informant William H. StallingsAddress Thomas Street, Cumberland Md17. Burial Date thereof March 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mr. Neman CemeteryLocation Cumberland (Rural) Md.18. Funeral director Louis Stein, Inc.Address Cumberland Md.19. Mar 10 19 48 Walter R. Pratz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 19 48 at 8:05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him xxx dead \_\_\_\_\_ 19 \_\_\_\_\_Immediate cause of death Coronary occlusion DURATION about 25 minutes

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. A.V. Deming M.D.  
Cumberland, Md. M. D. or Gen. 3.8.48

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

MAR 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02367

Reg. Dist. No. 8

## 1. PLACE OF DEATH

County Allegany  
 City or town Conasaconing  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year - 1 mo.  
 Hospital, institution, or street address where death occurred:  
\_\_\_\_\_  
 How long in hospital or institution? 1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Conasaconing, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no

## 3. (a) FULL NAME

Sallie Marie Steele

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Child  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) February 18, 1947  
 6. (c) If alive, give age 1 years  
 8. AGE: Years 1 Months 1 Days 6 If less than one day  
\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 March 1948 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on 7 March 1948  
 Immediate cause of death Pneumonia  
Lobar (4/23/48 - 22)

## DURATION

9. Birthplace Conasaconing, Allegany Co., Md.  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

none

12. Name Charles Steele  
 13. Birthplace Wood, Md.  
 14. Maiden name Bertha Lake  
 15. Birthplace Silmore, Md.

16. Informant Mrs. Charles Steele  
 Address Conasaconing, Md.

17. Burial Date thereof March 26, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Horseshoe, Md.

18. Funeral director M. J. Eichhorn

Address Conasaconing, Maryland

Mar 26 1948 Registrar Janette H. H. H.

(Date rec'd by registrar)

Registrar

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John B. Davis, M.D.  
2 Broadway, Baltimore, Md.

Address 2 Broadway, Baltimore, Md. Date signed 24 March 1948

RECEIVED

APR 3 1948

BUREAU V. S.



Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02368

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.Hospital, institution, or street address where death occurred Allegheny HospitalHow long in hospital or institution? 2 wks.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 417 Valley St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Ella Sticher

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Wm. A. Sticher

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 24 1884

8. AGE:

Years

Months

Days

If less than one day

6407hrs.min.

9. Birthplace

Hancock Ind.  
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

At Home

FATHER

12. Name

Robert Grooms

13. Birthplace

Ind.

MOTHER

14. Maiden name

Catherine

15. Birthplace

Hancock, Ind.

16. Informant

Wm. A. Sticher

Address

Cumberland

17. Burial

April 3 48

(Burial, cremation, or removal, which?)

Date thereof (month) (day) (year)

April 3 48

Cemetery or crematory

St. Peter & Pauls Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc.

Address

Cumberland Ind.

19. April 3 48

19 48

Cord. Trautz M.D.

Regist.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 48 at 6:53 P. M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 3/5 19 48, to 3/31 19 48and that I last saw her alive on 3/31/48 19 48

Immediate cause of death

Cerebralarteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cerebralarteriosclerosis

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John H. Rogers M.D.Address Cumberland Ind.Date signed 4/1/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS AIS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Days  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution? 2 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Westernport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 133 Wood St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Agnes Stuart

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Robert Stuart

7. Birth date of deceased (mo., day, yr.) August 7 1874  
 6. (c) If alive, give age 73 years

8. AGE: Years 73 Months 6 Days 25 If less than one day  
 hrs. min.

9. Birthplace Westernport, Allegany Co., Maryland  
(Town, county, and state)10. Usual occupation House11. Industry or business tt12. Name Patrick A Grant13. Birthplace Westernport, Md.14. Maiden name Rose South15. Birthplace Westernport, Md16. Informant Robert StuartAddress 133 Wood St, Westernport, Md.

17. Burial Date thereof 3/5/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peters CemeteryLocation Westernport, Md.18. Funeral director Harold FredlockAddress Piedmont, W. va.

19. March 3 19 48 W. A. Va M.D.  
 (Date rec'd by registry) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 48 8-35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Feb. 48 19 48  
 and that I last saw h. alive on 1 Mar. 48 19 48

Immediate cause of death subacute yellow atrophy liver 9 mts  
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Va M.D. or other  
Cumt. Md. Date signed 2 Mar 48

Address Date signed

RECEIVED

MAR 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02370

Reg. Dist. No. 14

## 1. PLACE OF DEATH:

County Allegany  
 City or town Corriganville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Corriganville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jennetta Clede Suder

## 3. (b) Social Security Number

4. Sex Fe 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William Suder  
 6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 13, 1894

8. AGE: Years 53 Months 11 Days 16 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Haysmills Pa.  
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business \_\_\_\_\_

FATHER 12. Name Henry Boger

13. Birthplace Penna.

MOTHER 14. Maiden name Lydia Dickey

15. Birthplace Penna.

16. Informant William Suder

Address Corriganville Md.

17. Burial Date thereof April 1 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Myersdale Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. 3/30/48 J. L. Lloyd Wolfe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 48 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19, 45 to Mar. 29, 48  
 and that I last saw her alive on Mar. 29, 48

Immediate cause of death Carcinoma of sigmoid colon  
 DURATION 2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John A. Lopper  
 M. D. or other \_\_\_\_\_

Address Hyndman, Pa. Date signed 3/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02371

Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County Allegany  
City or town Mt. Savage, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution? Dead on arrival, at Miner's Hospital, Frostburg Md.

### 3. (a) FULL NAME

Henry J. Sweeney

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Edna Uhl Sweeney

6. (c) If alive, give age 66 years

7. Birth date of

deceased (mo., day, yr.) Aug. 2 - 1879

8. AGE:

Years

Months

Days

If less than one day

68

7

5

hrs.

min.

9. Birthplace Mt. Savage Md.

(Town, county, and state)

10. Usual occupation retired, was a stationary

11. Industry or business engineer for C&P R.Ry.

FATHER

12. Name John A. Sweeney

13. Birthplace Mt. Savage Md.

MOTHER

14. Maiden name Christine Hergott

15. Birthplace Wellersburg Pa.

16. Informant Francis H. Sweeney (son)

Address Cumberland Md.

17. Burial Date thereof March 10 '48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Georges Cemetery

Location Mt. Savage, Md.

18. Funeral director F. J. R. Durst,

Address Frostburg, Md.

19. 3-10  
(Date rec'd by registrar)

48 Mrs. Nancy & Rue  
Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (b) Social Security Number

712-14-1535

### MEDICAL CERTIFICATION

about

20. DATE OF DEATH March 8 19 48 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive in Dead March 8 19 48

Immediate cause of death

Coronary thrombosis

DURATION

15 min.

Due to Coronary arteriosclerosis

5 weeks

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.  
M. D. or other \_\_\_\_\_

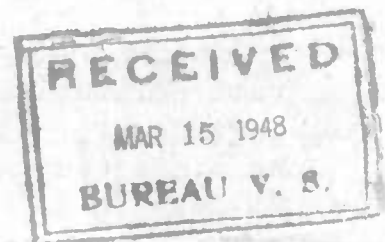
Address Cumberland Md. Date signed 3-8-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

596

02375

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

Allegheny HospitalHow long in hospital or institution? 1 day

## 3. (a) FULL NAME

Wm. Henry Thomas

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Bertie Saurbaugh

## 7. Birth date of deceased (mo., day, yr.)

Dec. 31, 1862

## 6. (c) If alive, give age

68 years

## 8. AGE:

Years

85

Months

2

Days

28

If less than one day

hrs.

min.

## 9. Birthplace

Gloucestershire, England  
(Town, county, and state)

## 10. Usual occupation

Carpenter (Retired)

## 11. Industry or business

Consolidation Coal Co.

## MOTHER

## FATHER

## 12. Name

Unknown

## 13. Birthplace

"

## 14. Maiden name

"

## 15. Birthplace

"

## 16. Informant

Mrs Wm Yeager

## Address

34 Weber St, Cumberland Md.

## 17. Burial

(Burial, cremation, or removal, Which?)

Burial

## Date thereof

Apr 1, 1948

## Cemetery or crematory

Allegheny Cemetery

## Location

Frostburg, Md.

## 18. Funeral director

John J. Haler

## Address

Cumberland Md.

## 19. Date rec'd by registrar

March 31, 1948

## Date

W. R. Faugh, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

Md

## County

Allegheny

## City or town

Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

## Street No.

443 Baltimore Ave.

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 29, 1948 at 8:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 15, 1948 to March 29, 1948and that I last saw him alive on March 29, 1948

## Immediate cause of death

General arteriosclerosis of blood vessels

## DURATION

## Due to

## Due to

## Other conditions

Chronic arthritis

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

B. M. Schneider

M. D. or other

## Address

41 Green St

## Date signed

March 31, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 3 1948 .

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

164c

02372

Reg. Dist. No.

9

## 1. PLACE OF DEATH:

County AlleganyCity or town Clarysville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kitchen, at Carioca Garden, Clarysville Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Clarysville Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 40  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Wilfred Vincent Tighe

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Elizabeth Davis Tighe6.(c) If alive, give age 36 years

7. Birth date of

deceased (mo., day, yr.) Dec. 13-1912

8. AGE:

Years

Months

Days

If less than one day

35314

hrs.

min.

9. Birthplace Frostburg Md.

(Town, county, and state)

10. Usual occupation Filtration Dept.11. Industry or business Celanese Corp. of Am.unknown

12. Name

"

13. Birthplace

14. Maiden name Lena Chambers

15. Birthplace

Frostburg Md.16. Informant Elizabeth Davis Tighe

Address

Clarysville Md.17. Burial Date thereof Mar. 30 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Michael's CemeteryLocation Frostburg, Md.18. Funeral director J. R. Durst,

Address

Frostburg, Md.19. 3-30  
(Date rec'd by registrar)19. 48 Mr. Harry H. Rao  
Registrar

## 3. (b) Social Security Number

220-10-8803

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 6:45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h. im. Dead March 27 1948

Immediate cause of death

Exsanguination, & Cardio-Pulmonary hemorrhageDue to Self inflicted 12 gauge Shotgun wound in left chest.  
Due to DespondencyOther conditions bronchial asthma

(Include pregnancy within 8 months of death)

Major findings of operations

.....Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 3-27-48Where did injury occur? Clarysville Allegany Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Kitchen at Carioca Garden, Clarysville Md.Means of injury as above Injured at work? yes, while Deputy Medical Examiner tending bar.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. orAddress Cumberland Md. Date signed 3-27-48DURATION  
about 2 min.several years

RECEIVED

APR 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02373

DR. GRACIE

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 33 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... STAR ROUTE, FLINTSTONE

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MRS. AMANDA TRAIL

## 3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife JAMES T. TRAIL

7. Birth date of deceased (mo., day, yr.) JANUARY 3, 1879

6.(c) If alive, give age 66 years

8. AGE: Years Months Days If less than one day

69 2 9 hrs. min.

9. Birthplace MARYLAND, Belle Grove

(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name ISAAC SWAIN (DECEASED)

13. Birthplace MARYLAND, Belle Grove

14. Maiden name ELIZABETH NORRIS (DECEASED)

15. Birthplace MARYLAND, Washington County

16. Informant James T. Trail

Address Star Route, Flintstone, Md.

17. Burial Date thereof March 15, 1948

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Piney Grove Methodist

Location Piney Grove, Md.

18. Funeral director John J. Raper

Address Cumberland, Md.

19. March 15, 1948 W.D. Fenz, M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 12 1948 at 1:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 Feb 8 1948 to March 12 1948

and that I last saw him alive on March 12 1948

Immediate cause of death Cardiac &amp; respiratory collapse

DURATION

Due to Operation, gall stones

Stones in common duct

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Stones in gall bladder &amp; common duct

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.D. Fenz

Address Cumberland, Md. M.D. Other

Date signed 3/15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02374

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Mumers Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Mt. Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Carol Jesse Trimble

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

October 8, 1936

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

1152

hrs.

min.

## 9. Birthplace

Mt. Savage, Allegany, Md.  
(Town, county and state)

## 10. Usual occupation

Student

## 11. Industry or business

Public school

## MOTHER

## 12. Name

Jesse E. Trimble

## 13. Birthplace

Mt. Savage, Md.

## 14. Maiden name

Susanna Weinbreimer

## 15. Birthplace

Mt. Savage, Md.

## 16. Informant

Jesse Trimble

## Address

Mt. Savage, Md.

## 17. Burial, cremation, or removal

BurialDate thereof Mar 13-1948  
(month) (day) (year)

## Cemetery or crematory

St. George's Cemetery

## Location

Mt. Savage, Md.

## 18. Funeral director

J. R. Priest

## Address

Frostburg, Md.

## 19. 3-12

48 Mrs. Quincy V. Roe

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948, at 5:55 P.M.21. I CERTIFY that death occurred on the data above stated; that I attended deceased from January 15 1948, to March 10 1948, and that I last saw him ER alive on March 10 1948.

## Immediate cause of death

Acute Nephritis  
Uremia

## DURATION

2 1/2  
months

## Due to

## Due to

## Other conditions

Extensive Primary  
Arteriosclerosis  
(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

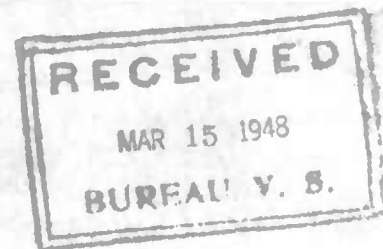
Injured at work?

## 23. SIGNATURE

William E. Moseley, M.D.

M. D. or other

Address Mt. Savage, Md.Date signed 3/11-1948





Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02376

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany  
County La Vale  
City or town La Vale  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
La Vale  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town LaVale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. LaVale  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME Paula Waldstein  
3.(b) Social Security Number None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Edmund Waldstein  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) May 18, 1878  
8. AGE: Years 69 Months 8 Days 13 If less than one day hrs. min.

9. Birthplace Vienna, Austria  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business

12. Name Edward Wiener  
13. Birthplace Prague  
14. Maiden name Klementine Cohn  
15. Birthplace Vienna, Austria

16. Informant Dr. Elizabeth Brings  
Address LaVale, Maryland

17. Burial Date thereof Mar. 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Hillcrest Burial Park  
Location Cumberland, Md.

18. Funeral director Charles L. George  
Address Cumberland, Md.

19. March 3, 1948 W.R. Brantz, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 1, 1948  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 1943 to March 1, 1948  
and that I last saw him or her alive on March 1, 1948

Immediate cause of death Cancer of the Physoid  
DURATION 2

Due to  
Due to  
Other conditions

(Include pregnancy within 3 months of death)  
Major findings of operations Cancer of the Physoid  
Date of op. 11/21/47  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Elizabeth Brings, M.D.  
La Vale, Md.  
Address Date signed 3/2/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

02377

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumtland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 82-6-5  
 Hospital, institution, or street address where death occurred:  
Allegheny Hospital  
 How long in hospital or institution 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
 City or town Cumtland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 410 Fayette St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Samuel Charles Wilkins

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced  
 6. (b) Name of husband or wife Adelaide Kirby  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Aug. 26 1865  
 8. AGE: Years 82 Months 6 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumtland Ind.  
 (Town, county, and state)  
 10. Usual occupation Paper Hanger Retired  
 11. Industry or business Coast Crier - Alley. Cr.  
 12. Name William Wilkins  
 13. Birthplace Penna  
 14. Maiden name Adelaide Charles  
 15. Birthplace Ind.

16. Informant Sommerville Busholom  
 Address Cumtland  
 17. Burial Date thereof Mar 3 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cem.  
 Location Cumtland  
 18. Funeral director Louis Stein Inc.  
 Address Cumtland

19. March 3 1948 W. L. Jantz, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 3:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9 1948 to Mar 1 1948  
 and that I last saw him alive on Mar 1 1948

Immediate cause of death Chronic myocarditis DURATION 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertrophied prostate 2 yrs  
and Retention of urine 3 wks.  
 (Include pregnancy within 3 months of death)

Major findings of operations urine bladder filled with blood clots & hypertrophied Date of op. Mar 1 1948

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

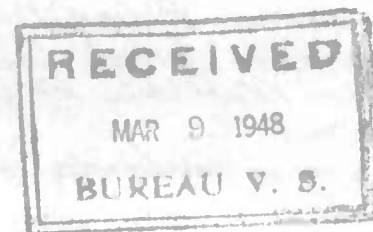
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. B. Irevastis, Jr. M.D. M.D. or other \_\_\_\_\_

Address Cumtland Ind. Date signed 3/2/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

02378

9

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... all his life  
 Hospital, institution, or street address where death occurred:  
77 Broadway  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 77 Broadway  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

EDWARD C. WILLISON

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.....

## 7. Birth date of deceased (mo., day, yr.)

April 30, 1870

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

78

10

10

hrs.

min.

## 9. Birthplace.....

Frostburg, Allegany, Md.

(Town, county, and state)

## 10. Usual occupation.....

Retired

## 11. Industry or business.....

Lumber dealer

FATHER

## 12. Name.....

Andrew Willison,

## 13. Birthplace.....

Flintstone, Md.

MOTHER

## 14. Maiden name.....

Missouri Hartzell,

## 15. Birthplace.....

Addison, Pa.

## 16. Informant.....

Miss Anna Willison,

## Address.....

Frostburg, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Mar. 13 '48

(month) (day) (year)

## Cemetery or crematory.....

Allegany Cemetery,

## Location.....

Frostburg, Md.

## 18. Funeral director.....

J. R. Durst,

## Address.....

Frostburg, Md.

## 19. 3-13

(Date rec'd by registrar)

48 Mr. Lacey &amp; Co. Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 11 1948 at 11:5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1948 to Mar 11 1948

and that I last saw him alive on Mar 10, 1948

Immediate cause of death

C. V. R. disease with hypertension

DURATION

10 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Frostburg, Md. Date signed 3/12/48

RECEIVED

MAR 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr P. E. Berry

Reg. Diat. No.

02379  
6

## 1. PLACE OF DEATH:

County Allegany  
 City or town Westernport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 months  
 Hospital, institution, or street address where death occurred:  
Walnut Street extended  
 How long in hospital or institution? - - - - -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Westernport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Walnut Street (ext)  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war - - - - -

## 3. (a) FULL NAME

BESSIE LEE WILSON

## 3. (b) Social Security Number

235-16-3746

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife - - - - -  
 7. Birth date of deceased (mo., day, yr.) January 17, 1881  
 8. AGE: Years 67 Months 2 Days 12 If less than one day - - - - - hrs. - - - - - min. - - - - -

9. Birthplace Westernport, Allegany, Maryland  
 (Town, county, and state)

10. Usual occupation Clerk  
 11. Industry or business Dry goods store

12. Name Jacob Wilson  
 13. Birthplace Lost River W. Va.  
 14. Maiden name Mary Jones  
 15. Birthplace Moorefield, W. Va.

16. Informant Mrs Charles Welsh  
 Address Westernport, Md.

17. Burial Date thereof April 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Philos Cemetery  
 Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal  
 Address Westernport Maryland

19. March 31, 1948 Registrar P. E. Berry M.D.  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 48 at 1:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to March 29, 1948  
 and that I last saw h. ER alive on March 29, 1948

Immediate cause of death

DURATION

CARCINOMA of the Vagina  
 Due to metastasis to Rect of  
 Due to body

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. - - - - -

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

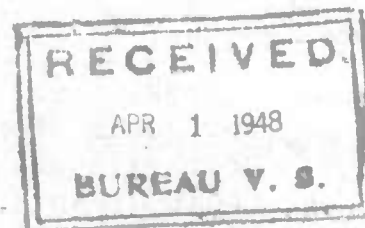
Accident, suicide, or homicide Date of - - - - -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) - - - - -Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE P. E. Berry M.D.  
Piedmont Ave  
 Address - - - - - Date signed 3/31/48

M. D. or other





DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02380

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 3

## 3. (a) FULL NAME

MR. JOHN W. WILSON .SR2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State MARYLAND County GARRETT  
City or town KITZMILLER, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED

## 6. (b) Name of husband or wife

MYRTLE PEW WILSON7. Birth date of  
deceased (mo., day, yr.)6. (c) If alive, give age 56 years

## 8. AGE:

Years

Months

Days

It less than one day

17747354

hrs.

min.

## 9. Birthplace

MARYLAND  
(Town, county, and state)

## 10. Usual occupation

Coal Miner - Retired

## 11. Industry or business

Coal Mine

MOTHER FATHER

## 12. Name

JOSEPH WILSON (DECEASED)

## 13. Birthplace

MARYLAND

## 14. Maiden name

ELIZABETH BRAY

## 15. Birthplace

MARYLAND

## 16. Informant

Address

## 17. Burial

(Burial, cremation, or removal, which)

Date thereof Mar. 15, 48

Cemetery or crematory

Northview Hill Cem.Location Elk Garden, W. Va.

## 16. Funeral director

Address

## 19. March 13, 1948

(Date rec'd by registrar)

W.R. Trout, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH, 12 19 48 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 7 19 48 to March 12 19 48and that I last saw him alive on March 12, 1948 19 48

Immediate cause of death

Coronary failure

DURATION

Due to

Asthma, Bronchial

Due to

Pneumonia, Bronchial

Other conditions

Sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

George M. Brown  
M. D. or other \_\_\_\_\_  
Address Memorial Hospital Date signed 3/12/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1948

BUREAU V. S.